EXHIBIT "S"

THE COURT: Sure.

(Discussion off the record.)

THE COURT: The People may call their next witness.

MS. BOOK: Thank you, Your Honor. The People call Dr. Carole Jenny to the stand.

CAROLE JENNY, after first having been duly sworn by the Clerk of the Court, was examined and testified as follows:

THE CLERK: The sworn witness is Carole Jenny, J-E-N-N-Y.

THE COURT: You may proceed, Ms. Book.

MS. BOOK: Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. BOOK:

Q. Good morning.

A. Good morning.

Q. Could you introduce yourself to the jury, please?

A. I'm Carole Jenny.

Q. And how are you employed?

A. I'm a professor of pediatrics at the University of Washington in Seattle, and I work with the Child Protection Unit at the Seattle Children's Hospital.

Q. What, exactly, does that entail?

A. We get consulted on all the possible abuse or neglect cases that come into the hospital. We do consults from the

community, from social service workers or police if they have questions about medical aspects and, you know, is this abuse; is this not abuse. I also do clinics at a hospital called Harborview Medical Center, which is the county hospital in Seattle. I see outpatients. Most of the outpatients that we see are sexually abused kids or kids where there's concern of sexual abuse.

We do research. We have something just established, a fellowship training program. We do a lot of teaching of medical students, residents, interns, community docs, other people in the community.

Q. How long have you been at the Seattle Hospital?

A. Since February.

Q. Okay. And why the recent move?

A. Well, we originally thought we were going to retire, but then when we got to Seattle, my husband and I were both offered really interesting jobs, so we didn't. So, we moved to Seattle, because that's my husband's home.

Q. Okay. Now, I'd like to turn to your educational background for a moment. Could you tell us where you went to college?

A. I went to the University of Missouri in Columbia, Missouri.

Q. And what year did you graduate?

A. In 1968.

Q. What degree did you obtain there?

A. A Bachelor's, a BA degree in zoology.

Q. Okay. And can you tell us about your postgraduate degrees?

A. I have a Bachelor's in medical science from Dartmouth Medical School and an M.D. degree from the University of Washington. And then after residency, during fellowship, I did an MBA at the Wharton School of the University of Pennsylvania.

Q. Can you tell us about any postgraduate training or fellowships that you participated in?

A. I was an intern in pediatrics at the University of Colorado and then a resident in pediatrics at Philadelphia Children's Hospital, and then I did a fellowship at the University of Pennsylvania. It was the Robert Wood Johnson Clinical Scholar.

Q. What does that mean?

A. Well, it's the Johnson Foundation, as in Johnson & Johnson Company, and the foundation has a program where they train or they give fellowship opportunities to physicians after they completely finish their medical training in related fields. I did mine in health services administration, health management.

Q. What certifications or licenses do you hold?

A. I'm licensed to practice in Rhode Island and in the State of Washington. I'm board certified by the American Board

of Pediatrics in general pediatrics and in child abuse pediatrics.

Q. Can you tell us about the subspecialty of child abuse pediatrics?

A. Child abuse pediatrics was a subspecialty established -- well, actually, the first exam was given in 2009, although people have been doing this work for quite awhile; but the Board of Pediatrics recognized it as a subspecialty of pediatrics in 2009.

Q. Did you have anything to do with that test?

A. Well, I wrote the first application to the Board of Pediatrics on behalf of the American Academy of Pediatrics asking that it be made a full subspecialty, justifying the need for a subspecialty.

Q. Would you like some water?

A. Yes. That would be helpful. Thank you. And I was on the board of their group for exams for the subspecialty.

Q. So, you actually wrote the exam in the subspecialty of child abuse pediatrics?

A. Yes.

Q. And are you current in both of those subspecialties that you are certified in?

A. Yes. I'm certified in both until -- well, actually, I'm certified in general pediatrics for life, but I have been taking the exams every seven years just to -- you know, I like

being up to date, and I'm also board certified currently in child abuse pediatrics.

Q. Okay. What do you mean that you are board certified for life but you take the exams anyway?

A. Well, until about 1985, if you passed your pediatric boards once, you weren't required to maintain certification; but then in about '90, they said, well -- in '85, they said from now on, everybody has to take an exam every six to seven years to show that they have maintained their qualifications. I took my last exam in 2010.

Q. And you do that voluntarily?

A. Yes.

Q. And have you passed all your exams?

A. Yes.

Q. Okay. You mentioned that you serve as a member of a faculty currently?

A. Yes.

Q. Can you tell us about that?

A. Well, the University of Washington is a very large medical school, the only one, actually, in about a five-state area on the Northwest part of the country, and I'm on the Department of Pediatrics. I'm a full professor.

Q. Can you briefly describe for us your employment history and any administrative positions you have held?

A. Well, I started out as -- at the University of

Washington after a fellowship with joint appointments in the department -- in the public health school and then in the medical school. And then when my children arrived, I quit and didn't work for seven years. I was a full-time mom, and then I went back to work after they were in school. At that point, I took a job at Harborview Medical Center in Seattle doing child abuse work, and I have been doing it ever since.

After I left Harborview, I did spend one year in private practice and then went to the University of Colorado and had a faculty appointment, and I was a medical director of a research group there. And then in 1990, I was recruited by Brown and I stayed at Brown until this past spring, this past winter.

Q. And what did you do at Brown?

A. I was a professor of pediatrics and I was the director of the Child Protection Program at the hospital, the affiliated children's hospital called Hasbro Children's Hospital named after the toy company.

Q. What hospitals have you had or do you currently have privileges at?

A. Currently, I have privileges at the -- at Harborview Medical Center and Seattle Children's in Seattle. Previously, I was at Hasbro Children's, and I also had privileges at Women and Infants Hospital in Seattle, which is where they deliver all the babies. And then before that, I was on the staff of

the Denver Children's Hospital; and before that, I was in Seattle.

Q. Can you briefly tell us some of your professional memberships?

A. Um, I'm a member of the American Academy of Pediatrics, the American Professional Society on Abuse of Children, the Forensic Science -- Academy of Forensic Sciences, the International Society of Prevention of Child Abuse. I guess those are the main ones.

Q. Okay. And have you been appointed to any national committees?

A. Yes.

Q. Can you tell us about those?

A. Um, I was, for several years, the chair of the Committee on Child Abuse for the American Academy of Pediatrics, which is sort of the body that represents 60,000 American pediatricians. I have been on the board of directors of the American Professional Society of the Abuse of Children, and I have been the -- a district vice chairman for District One in the Academy of Pediatrics, which is all of New England and part of Canada.

Q. Have you been on any state and local committees?

A. Yes.

Q. Can you tell us about those?

A. Oh, gosh, a lot. I have been on -- I founded Death

Review in the State of Rhode Island, where we review every child's death, and I was the chair of that for five years. I have been on advisory committees to the Legislature. I worked with the Attorney General's Office on a committee that defines standards for sex offender categorization, when they first had sex offender notification legislation. I have done -- been an advisor to the State Child Advocate.

I have worked with the Centers for Disease Control, the CDC, in Atlanta on devising protocols for the evaluation of children and for defining head injuries in children. I have been on study groups with the National Institutes of Health that analyze grant proposals; lots of things.

Q. Okay. Now, just for a moment, I want to talk about the Death Review team that you did. Can you tell us about that and what exactly that was?

A. Well, over the last 20 years, most states have begun to look very carefully at child deaths, and the whole point of doing it is to look for areas of prevention. So, we organized the team in Rhode Island - I'm not sure what year - maybe '98, maybe, because they had not had a child death review team, and this included the medical examiner, law enforcement people, social services people, people from family organizations, the SIDS organization, sudden infant death syndrome support group. And we would, as a group, we would review difficult cases; but as a panel -- there were three of us that reviewed every death

in the State of Rhode Island in any child under 18, and the idea was to look for patterns so we could deal with prevention, and we did -- we did a lot of drowning safety promotion. We have done safe sleep promotions for infants, helmet programs, bicycle safety and so on.

So, as a group, the death review panel would identify how and why are kids dying, why are we losing our babies and our youngsters, and then try to think up good ways to make that better and make the environment safer. I also was on death review at -- I was on the committee. I didn't run it, but I was on it in Colorado. That's why I started it in Rhode Island.

Q. Can you approximate how many children's deaths you have reviewed?

A. Well, in Rhode Island, we had, I think, 170 a year. That's from birth to 18. So, obviously, I did that for five years. And then, of course, I'm involved in a lot of child death cases in my other role as a child abuse pediatrician.

Q. So, would it be fair to say you have reviewed thousands of child death cases?

A. Well, let's see. Well, at least a thousand, I would say. I have been doing this for 30 years.

Q. Now, when you review a child death case, what do you look at?

A. Everything, everything I can get my hands on; police

records, social service records, all the medical records, birth records, prenatal records, well-child care records; you know, a lot of times kids are involved with other agencies, like WIC, the supplemental feeding program, and they keep records of a child's growth and development. If it's relevant, we look at school records, you know, depending upon what the nature of the case is. So, it's an extensive process.

Q. Have you been elected to any positions?

A. Um, I have been the president of the American Academy of Pediatrics in Rhode Island. I have been elected to the Board of the American Professional Society For Abuse of Children. I was elected to serve on the section -- and then I was the chair of the Section on Child Abuse For the American Academy, which does all the educational materials and plans for continuing medical education.

Q. Have you had the opportunity to consult in your field?

A. Yes.

Q. In what ways?

A. Well, I have consulted with hospitals that are -- you know, they are either having problems with their Child Protection Program or they want to, you know, to get it reviewed and kind of get a grade card. I have, again, consulted with CDC and NIH. I have done consultation, you know, for -- in lots of legal cases. I have done, you know,

legal consultation, medical legal consultations in England, Wales, New Zealand, Canada and in several states in the U.S.

Q. Have you been published?

A. Yes.

Q. How many times?

A. I haven't counted recently. I have eight books that I have edited or co-edited, and I have had about 40 book chapters and way over a hundred scientific publications in medical journals.

Q. Those eight books that you have written, what are they and what are they about? You don't have to say all of them, but generally?

A. Most recent was a large textbook for physicians on child abuse, great big thing, and child abuse and neglect; and then I have also recently published a book called *Medical Child Abuse*. That is about kids that get excessive unnecessary medical care, how it can hurt them; and the others have been on physical abuse, sexual abuse of children.

Q. What other topics have you published on?

A. Well, my main -- early on, I published a few basic science papers when I was in medical school. And since I have been in this field, I have published on sexual abuse, on sexually transmitted diseases, on failure to thrive and neglect; and most recently, in the last ten years, most of my work has been in the field of head trauma and child death.

Q. What, specifically, do you publish on with respect to head trauma and child death?

A. Epidemiology, meaning you know where and when it happens, how to recognize it, biomechanics. I worked for five years in a biomechanics laboratory with a head injury research group in Japan and just, you know, lots of different aspects of head trauma. I did one study on coagulation problems in babies with head trauma; you know, many different studies.

Q. Can you briefly tell us about your work in Japan?

A. Well, the crash test dummies that people use to analyze infant injuries in the U.S. are very -- they are not very well engineered, and a private lab, actually, in Japan, built their own set of dummies that are very, I guess you would say, advanced, very biofidelic. And, so, I happened to meet these people at a pediatric meeting, a scientific meeting, and they then hired me to work with their team in designing infant head trauma studies using their particular amazing laboratory, which was just a wonderful experience.

Q. What, exactly, did you look for during that?

A. We studied all kinds of things. We looked at car crashes. We studied accidental injuries, lots of different kinds of falls and things that occur to infants in accidents, just look at the biomechanics of what their head experienced, and then we also looked at abusive injuries that were modeled by these dummies or on these dummies.

Q. Have you lectured in your field?

A. Yes.

Q. Approximately how many times?

A. Oh, hundreds, in lots of different countries. I often give lectures. Most recently, I have been in Sweden and Israel and France within the last year, and then I have lectured medical meetings all over the U.S.

Q. Have you testified in court before?

A. Yes.

Q. Approximately how many times?

A. Um, about once or twice a month. Most of the cases are cases where I actually --

MR. COFFEY: Objection. She wasn't asked why. She was asked how many times.

THE COURT: Overruled.

Q. You can continue.

A. Most of the cases that I do are kids -- are my patients, kids that I see and then they are going to Family Court to decide where the child should live, and I also do other cases, you know, get hired by other jurisdictions to look at child death cases and child abuse cases.

Q. Have you been qualified as an expert witness in court before?

A. Yes.

Q. In what courts have you been qualified?

A. In County Courts, State Courts in the U.S., in courts in, again, New Zealand and Wales and England and Canada, and I also testified before the -- the Courts of Appeal in England, which is kind of like their Supreme Court. And, so, I have been -- and in court-martials -- courts-martial in military cases and in Family Court. I'm sorry.

Q. That's okay. Have you received any honors or awards in your field?

A. Yes, I have.

Q. Can you briefly tell us about some of those honors and awards?

A. I was the recipient of the Outstanding Contribution to Child Abuse and Neglect Award given by the American Academy of Pediatrics. I was given a nice award by the National Association of Children's Trust Funds, again on the issue of preventing child abuse. I was given an award by the American Professional Society on Abuse of Children for my work, for outstanding professional in child abuse. I have been given two awards by the Federal Government for my work in child abuse.

Q. Did there come a time that you were contacted by the Rensselaer County District Attorney's Office to consult on a case involving the death of [redacted] [redacted]?

A. Yes.

Q. And are you being compensated by the District Attorney's Office for your time and consultation on this case?

A. I am.

Q. How much are you being compensated?

A. $300 an hour for record review and for testimony.

Q. Do you testify for both the prosecution and defense?

A. Yes.

Q. Do you testify for the prosecution more than you do the defense?

A. I do.

Q. Why is that?

A. Well, I never refuse -- I rarely refuse to review cases, unless I'm just way far behind and don't have enough time. If I review a case for the defense and I say, "Gee, I think this is abuse," they are obviously not going to call me to testify. And I have done that with prosecution cases. I say, "I don't feel comfortable testifying in this case because I don't think this is, you know, the right thing," and then they don't call me, either. What usually happens in those cases, though, is the case gets dropped.

MR. COFFEY: I object to this as nonresponsive. She wasn't asked whether they get dropped.

THE COURT: Overruled.

A. Not always. Some cases, they go ahead and proceed with the case, and that's their choice.

Q. Okay. And specifically, have you testified in other cases for the Rensselaer County District Attorney's Office

before?

A. I think this is like the fourth time I have testified here.

Q. Okay. Did you review any records prior to coming here today?

A. Yes.

Q. Can you tell me what records you reviewed?

A. Um, the prenatal care records for [redacted] [redacted]' mother, his birth records, his postnatal records, his well-child care records and records of a hospital visit, emergency visit on September 13th of -- 2009? No. I forgot what year. September 13th. And then also a prolonged hospital record beginning in September of -- 21st. I forget what year it was.

Q. That's okay.

A. I'm sorry. And then I reviewed the autopsy report, police records, social service records.

Q. Now, let's start at the beginning and talk about the prenatal history of Wilhemina Hicks. You just testified that you reviewed the prenatal history and OB-GYN records of [redacted]'s mother. Did she have any prenatal or pregnancy problems?

A. She had pregnancy induced hypertension.

Q. What does that mean?

A. It used to be called toxemia, but it's a problem that

develops in some pregnancies, where the mother gets very high blood pressure and oftentimes will have some kidney problems, as well, and it can be fatal to mothers. Obviously, it's something people watch for very closely. This was a twin pregnancy, which always is more complicated than a non-twin pregnancy. Mother had some difficulties with her blood sugar and, you know -- and she went into premature labor, had premature rupture of her membranes, early rupture of her membranes and then went in and delivered the babies vaginally.

Q. Okay. Now, when we say premature rupture of the membranes, does that just mean your water broke earlier than 40 weeks or what does that mean?

A. Well, it broke before delivery, too early, and it's just, you know, something that they watch. Once the water breaks, they would rather get the baby out within 24 hours or 12 hours, even better, because that just increases the risks to the baby.

Q. Okay. Do you know whether or not there was any meconium involved in this case?

A. Meconium? There was staining of the fluid, of the amniotic fluid that came from the uterus. There wasn't, to my understanding, frank meconium, which is essentially fetal poop; but when one of the babies has released meconium, the fluid takes on kind of a greenish tint.

Q. And what is the risk of that?

A. Well, if you aspirate -- if the baby is born and when they take their first breath -- they actually have meconium in their mouth and they aspirate it into their lungs. It causes very severe pneumonia. So, when you are at a delivery and you are delivering, as the pediatrician, you get the baby and there's meconium present, generally before the OB delivers the baby, he will try to suck it out with suction; and then when the baby is delivered to the pediatrician, you intubate the baby to look beyond the cords to see if there's meconium down, you know, beyond the vocal cords that can get then into the lungs. If there is, you wash it out with saline. You don't want that stuff to get into the lungs. That's very critical.

Q. Now, in this case, there's been some mention of the meconium. Was it to that extent at all?

A. No. There was some staining of the fluid.

Q. What does that mean?

A. There was some meconium -- some babies are born just with frank sticky black meconium around their mouth and around their body. If they at some point during the delivery process have -- excrete some meconium, it can make the fluid a different color. It's just a sign that the babies are in distress and we want to get them out.

Q. Was there a concern for anyone aspirating meconium in this case?

A. Neither of these babies aspirated.

Q. Was [redacted] [redacted] born premature?
A. Yes.
Q. At how many weeks gestation?
A. I believe 33 weeks.
Q. Is there a degree of prematurity and a degree of full term?
A. Yes.
Q. Could you tell us about that?
A. Well, ideal is around 38 to 40 weeks; and generally, 37 to 35 is considered mildly premature, and those kids have different problems, other than real premature babies. From 35 weeks down to 29 weeks or to 30 weeks, they are considered premature; and less than 30 weeks, they are exceedingly premature. Now they are delivering babies at 24, 25 and 26 weeks and resuscitating them and keeping them alive and, obviously, they are very high risk babies.
Q. So, being that [redacted] was born at 33 weeks gestation, where did that place him on the prematurity scale and what risks are associated with that?
A. Well, he's midrange. The problems that can happen are lung disease, chronic lung disease, low blood sugar, low body temperature, difficulty feeding. Those are -- that age range of kids, those are things you look for.
Q. Is there anything that can be done to improve the lungs?

A. Well, are you talking about this individual case or any case?

Q. Well, in any case, is there anything that can be done to help improve the lungs?

A. Yes.

Q. What is that?

A. Well, depending on the nature and degree of the lung disease, you put kids on ventilators and give them support until their lungs mature. You can give them -- give the mother steroids before delivery to decrease the likelihood of lung disease.

Q. Why do you give steroids?

A. Because it decreases the amount of inflammation and there's less chance the baby will develop severe lung problems.

Q. Do you know if Wilhemina received that steroid shot?

A. Yes, she did.

Q. And is that helpful towards the babies when they are delivered?

A. Yes.

Q. Now, was there any birth complications with [redacted]?

A. [redacted] did require some oxygen. His initial -- when babies are born, you give them a score called an Apgar score. That kind of is a score of how well they are adapting to neonatal life, their life outside the uterus, and you do it at one minute and five minutes. His first was low. He was

stimulated and given oxygen; and his second was nine, which is fabulous. So, he very quickly came around. He did require some oxygen in the nursery. He never was on a ventilator. He never required, you know, serious respiratory support. He had -- he was hypothermic, which means kind of had a hard time maintaining his body temperature, which is normal for these kids, but it's something you really watch; and he did receive a workup for a possible infection, but that was negative.

Q. Okay. Now, the Apgar's that you were talking about, what do they assess?

A. Breathing, color, movement, strength of baby's cry. It's kind of a rapid assessment to see whether the baby is going to be in bad trouble or whether they can make that adaptation to extrauterine life on their own.

Q. Now, is one of the scores predictive of how you are going to do?

A. Well, I think certainly, by five minutes, you want the kid to have a normal Apgar; and if they don't at one minute, you are certainly going to give them oxygen and do what you have to do to make sure that they have a good start.

Q. So, the fact that [redacted]'s Apgar was a nine at five minutes, what did that indicate to you?

A. That's good. That means he made an adaptation. He responded to the therapy. He did well. For a 33-week-old baby, he really had a fairly uncomplicated course.

Q. When [redacted] was born, other than what you have already described, were there any other health concerns?

A. Um, he had some difficulty gaining weight and had the normal preemie feeding issues, but he did well and didn't have any -- when he left the hospital, he was a normal baby.

Q. What is a trivalvular pulmonary stenosis?

A. That's when the pulmonary valve, the valve between the atrium and the ventricle, is a little constricted, is constricted.

Q. Was that present at all in [redacted]?

A. You know, they said it was. They heard a murmur. They did an ultrasound and said it was, but four months later on autopsy, and also on ultrasound or on Doppler study of his heart, echocardiogram, he had perfectly normal valves. So, if it was there, it wasn't ever -- it didn't ever affect him in terms of his ability of his heart to function; and at the time of his death, he had very normal cardiac function by the ultrasound.

Q. How was [redacted] during his stay at Albany Medical Center?

A. At Albany?

Q. Yes.

A. The first time or the second time?

Q. The first time after he was born.

A. He did well. He, again, needed oxygen. He did get a

short course of antibiotics, but his cultures were negative and he required help with feeding and staying warm, the typical kind of preemie problems.

Q. At some point, was he transferred to another hospital?

A. Yes.

Q. Where was he transferred to?

A. They sent him home to St. Mary's.

Q. And why would they send a premature newborn to another hospital?

A. Well, depending on the level of the intensity of care he needed. If they don't need intensive care, it's certainly much more convenient for the family if he's at a local hospital, rather than a hospital that's farther away. It's mostly for the convenience of the family, but it's common to have people step down from a high level to a midlevel to a regular nursery.

Q. Okay. And did you review his records at St. Mary's Hospital?

A. Yes.

Q. How was he during his stay at St. Mary's?

A. He did well. He grew, and he basically just matured to the point where he was perfectly safe to go home.

Q. Was there any indication to you that [redacted] [redacted] had intracranial bleeding or was born with any type of subdural

hematomas?

A. Well, he didn't have any seizures or neurologic issues as a newborn. He did have, I think at about 10 days, ultrasound, and that is a study that looks at just the part of the brain that's underneath the soft spot on top of the head. So, you only see, you know, this kind of region of brain, but it was perfectly normal. They didn't see any excess fluid.

Q. In your experience, is an ultrasound an accepted method of checking premature babies for intracranial bleeds?

A. Well, certainly, they do it.

MR. COFFEY: She didn't ask what they do. She asked whether it's acceptable and I object.

THE COURT: The objection is sustained.

A. I'm sorry?

Q. That's okay. In your experience, is an ultrasound an accepted method of checking premature babies for an intracranial bleed?

A. Yes.

MR. COFFEY: I object to this as outside of her expertise.

THE COURT: The objection is sustained on foundation.

Q. Dr. Jenny, during your 30 plus years in practice being a pediatrician, have you had the opportunity to review the results from ultrasounds of premature babies?

A. Yes.

Q. How many times?

A. Many.

Q. Have you ever yourself ordered that an ultrasound be done on a premature baby?

A. Yes.

Q. Why is that?

A. Because there's no bad side effects. It's not like a CAT scan that radiates the baby's head. It's not like an MRI that, until recently, required deep sedation and had some kind of risk. So, it's kind of an easy -- it's an easy, fast, nonintrusive way to look at babies, the front part of their heads, which is where they often get bleeds if they are premature.

Q. So, in your experience, is this an accepted method of checking babies for intracranial bleeds?

A. It's standard for all babies that are premature.

Q. And was there any indication that [redacted] had an intracranial bleed or was born with a subdural hematoma?

A. It certainly didn't happen around the top of his head. He also didn't have any what we call germinal matrix hemorrhages - which is really why people do the study - which are deep bleeds in the brain that preemies can get that can lead to neurologic problems.

Q. Are you familiar with any studies or statistics with

studying newborn babies and whether or not they have bleeds?

A. In the head?

Q. Yes.

A. Yes.

Q. Can you tell me about those?

A. Well, for many years, people only got imaging studies on kids that were in big trouble or something was obviously wrong with them, either a very complicated delivery or had abnormal neurologic exams. It started about ten years ago, I think, but most recently, those studies have been done in the last ten years. People have done studies on normal newborns where they do rapid sequence MRI's that don't require sedation and, surprisingly, found that 25 to 46 percent of normal newborns that are perfectly healthy will have small amounts of bleeding in the backs of their heads, down low in what's called the posterior fossa, or just in this part of the brain (indicating).

And the studies that have been done, where they followed the normal children that have those small bleeds, they find that they are gone in a month to six weeks and kids don't have any long-term ill effects that we know of.

Q. Are those children symptomatic?

A. No.

Q. And what does that mean?

A. Well, that means that they -- this was the first time

anybody started doing those kinds of studies on normal children that didn't look like they had bad brain disease. And, so, that was -- it was surprising because nobody has ever looked at normal newborns before.

Q. What type of bleeding are we talking about that these children had in these studies?

A. Subdural or small amounts of subarachnoid bleeds or sometimes even small bleeds within the brain substance itself.

Q. Does it rise to the level of a subdural hematoma?

A. Yes.

Q. Okay. And would you expect to find a subdural hematoma that was present since birth on an ultrasound of an infant's brain?

A. Well, it depends on where it's located. If you have subdurals right, you know, in this part of the head, you can see them very well on ultrasound, because they really don't look like regular subarachnoid fluid. If they are in the back, you can't see that with an ultrasound. You can only look at the parts where there's a nice soft spot that you can put your transducer in to do the measurements.

Q. Going back to the St. Mary's stay for a moment, were there any health concerns for [redacted] during his stay at St. Mary's?

A. Not that I recall, other than normal growing and gaining.

Q. Was he growing and feeding appropriately?

A. By the time he left, he was doing well.

Q. Was [redacted] eventually sent home from St. Mary's?

A. Yes.

Q. Do you remember about how old he was when he was sent home?

A. He was about five weeks, I think, ten weeks? I can't remember. I'm sorry.

MS. BOOK: If I may have a moment. May I approach, Your Honor?

THE COURT: You may.

Q. Dr. Jenny, I'm going to show you what's in evidence as People's Exhibit Number 11. If you could take a look through this and see if you can refresh your memory as to when he went home.

A. Looks like 5/22 and he was born 5/9. Is that right? Let me find the discharge. 5/22.

Q. He was sent home?

A. Uh-huh.

Q. Thank you. Were there any specific instructions given to Wilhemina Hicks for addressing any health concerns?

A. I think the main issue was frequent feeding. Babies that age, you need to feed more frequently than you do a normal baby or a full-term baby.

Q. Now, in those records, some say [redacted] Hicks; some

say [redacted] [redacted]. Are they referring to the same person?

A. I think Hicks was the mother's name before she was married.

Q. Okay. So, why might it have [redacted] Hicks on some of the records?

A. That's generally -- when you have a newborn baby, you admit them under the name of the parent that delivered them so you can kind of keep track of them, and then I guess when people fill out the birth certificate, they have the option of using the father's name or the mother's name.

Q. Okay. Did [redacted] receive all of his recommended follow-up care with his pediatrician?

A. He did.

Q. Was he up-to-date with his immunizations as of September of 2008?

A. Yes.

Q. As of September of 2008, how many shots did [redacted] have for streptococcus pneumonia?

A. One at two months of age.

Q. Out of how many shots?

A. You have them at two, four, six months and a year, a series of four.

Q. And in your experience evaluating thousands of child deaths over the course of your career, can you tell us, do a significant number of children die from streptococcus pneumonia

before they are able to get all four shots because they are not fully immunized?

A. Um, I haven't -- well, certainly in the five years --

MR. COFFEY: I object to this, the fact she's asking an opinion. I think it's outside her field, unless she's qualified to do this.

THE COURT: Overruled.

A. When we did death review, the five years that I ran that, we had none at the Children's Hospital.

MR. COFFEY: I object to that as an incomplete statistical survey, just because her hospital found none.

THE COURT: You can cross-examine her on that topic. The objection is overruled.

A. Now that we have the immunizations, it's rare. Before we had immunizations, it was a very common problem. Kids would come in with meningitis or pneumonia from strep pneumonia and be very, very ill.

Q. How long ago was that?

A. When did they start immunizing? Oh, I think about -- I can't even remember, some time within the last 20 years; probably ten years ago maybe.

Q. Okay. Did [redacted] have any health concerns the entirety of the summer of 2008?

A. Other than his mother using -- it was still in the summer. His mother used a cleaning chemical by mistake on his

cheek and he got some dermatitis on his cheek that he was treated for on the 13th. Otherwise, he had normal well-baby care.

Q. On the 13th of what?

A. September.

Q. Doctor, were you able to review [redacted]'s head growth from the time of birth until his admission at Albany Medical Center?

A. Yes.

Q. Could you tell us about that?

A. It was perfectly normal until his last admission, when he came in with subdurals.

Q. Why is head growth measured?

A. It's very important because it reflects brain growth and, of course, you want to make sure -- babies' heads double in size in the first year of life; and if the head is not growing, you get very worried because that means the brain is not expanding the head. And if the head grows too much, you know, like if the child comes in for their two-month check and their head has gotten quite large, you are going to be very concerned that there may be something wrong. There may be fluid in the brain, for instance, or they may have a condition called hydrocephalus, which is a congenital condition where too much water on the brain occurs.

Q. And do you recall, at [redacted]'s two-month visit,

where his head fell in the head circumference growth chart?

A. He was growing at a normal rate. It was consistent with his birth and early records.

Q. Now, in your experience, do you have any knowledge with respect to whether or not subdural hematomas would cause your head to grow?

A. Well, you always look at head growth as a measure of the age of the subdural. If the child started off at birth and the head gradually expanded beyond what it should, you need to be very concerned that there was a chronic problem. But if it's growing normally and then suddenly jumps, you know, we use that to kind of -- as a proxy measure for timing of injury.

Q. What do you mean by that?

A. Well, you know, if the head is growing normally, there's not -- the brain is normal and the baby is neurologically normal, they are not likely to have extra fluid in their head.

MR. COFFEY: Objection. This is outside her area.

MS. BOOK: Your Honor, I asked if this was in her experience.

THE COURT: The objection is overruled.

A. What was I saying? And then when you see that sudden jump in the head circumference, you go, "Oh, there must be something going on" that started between this visit and that

visit.

Q. Okay. Now, do you recall, based on your review of the records, where [redacted]'s head fell in the growth chart after going to the hospital on September 21st?

A. He had to have had a large jump in his head circumference.

Q. Okay. How large of a jump; do you recall?

A. I don't know.

Q. Okay. Well, based upon your review of the records, the jump in the head circumference from his two-month check to the Albany Med admission on September 21st, what, if anything, did that indicate to you?

A. That he had had abnormal head growth in that time period.

Q. Doctor, are you familiar with the term called sepsis?

A. Yes.

Q. Okay. So, we have heard a lot of words during the course of this trial. We have heard bacteremia, sepsis, septic shock. Are they all related? Can you tell us what they are and what the differences between them are?

A. Sepsis means you have microorganisms in your blood, and that could be viruses, bacteria or fungus. So, sepsis just is a term meaning you have an infected bloodstream. Bacteremia means you have bacteria in your bloodstream, and septic shock is a complication, usually, of bacterial sepsis, where the

bacteria releases toxins that cause the blood pressure to become very low and clotting abnormalities to happen.

Q. Okay. So, people who get bacteremia, does it always necessarily turn to sepsis?

A. Well, they are one and the same. I mean, if you have bacteremia, you are, quote, septic.

Q. Okay.

A. But there are other things that can cause sepsis besides bacteria.

Q. Okay. And is there varying degrees of this?

A. Yes.

Q. Can you tell me about that?

A. Well, you know, sometimes patients will actually, you know, get complete physical collapse from having sepsis in their bloodstream. In other kids - you know, it's a finding - they have a fever and you take blood cultures just to make sure, and you are surprised because they don't look that sick. So, it really depends on how much, how bad and what the organism is.

Q. What are some of the signs and symptoms of sepsis?

A. Well, one of the things that we see is that kids come in with these horrible rashes. They have big blue blotches on their skin from bleeding problems and they kind of look bruised all over; low blood pressure, trouble keeping your temperature up, dropping your white count, abnormal blood clotting.

Q. Now, the rash that you just described that you will see on children who get sepsis, is that the same kind of rash that [redacted] presented with on September 13, 2008, at the Samaritan Hospital?

MR. COFFEY: Objection, unless she can testify that she read the record and can identify it.

THE COURT: I'm sorry?

MR. COFFEY: She never identified that she even saw that record.

MS. BOOK: Your Honor, she did review -- indicated that she had seen the record.

THE COURT: That objection is overruled.

Q. I'm sorry. I lost my train of thought. The type of rash that you were talking about that is associated with sepsis, is that the same type of rash that was present on [redacted] at the September 13th visit at Samaritan Hospital?

A. No.

Q. Why not?

A. This rash is very distinctive. You get these blue blotches, basically, and they are under the skin. They are not raised, and it's just -- it's different. It's not like a blistery thing on the cheek.

Q. Okay. Now, at [redacted]'s appointment on September 13th at the Samaritan Hospital Emergency Room, what happened on that date?

A. Um, they told her to stop using wipes. I don't think they gave her any medication. Nobody was particularly concerned about it. It would heal itself once the toxin or the chemical that was irritating him was no longer present.

Q. Was [redacted] exhibiting any signs or symptoms of sepsis on September 13, 2008?

A. No.

Q. Was he exhibiting any signs or symptoms of any type of a bacterial disease on September 13, 2008?

A. No.

Q. And is there any indication that that rash on his face ever became infected or inflamed in any way?

A. There was never any indication that it was infected.

Q. Now, I want to talk to you about the morning of Sunday, September 21, 2008.

THE COURT: Before you do that, Ms. Book, members of the jury, at this point in time, we are going to take a ten-minute break. During the course of this break, please do not discuss the case among yourselves or with anyone else. Do not read or listen to any media accounts of this case. Do not form any judgments or opinions about this case. Do not request or accept any payment in return for supplying any information.

Members of the jury, just so you understand today's schedule - because I haven't talked to you about

this yet - but it is going to be slightly different than our typical schedule. We are going to take a ten-minute break now, as I indicated. We are then going to work right up until noon. At noon, we will break for lunch for one hour until one o'clock; and at one o'clock, we will resume only until 2:30 today. We can't go all the way until 4:30 today, but we will go till 2:30. So, I just want you to be aware of how today is anticipated to progress. With that said, we will break for ten minutes at this time.

(Jury excused.)

THE COURT: Doctor, because you are still giving sworn testimony, I will ask that during this break, please don't discuss this case or your testimony with anyone. That includes the attorneys involved in this case. Okay?

THE WITNESS: Yes.

THE COURT: Thank you. See you in ten minutes.

(Brief recess taken.)

(Proceedings continue outside the presence of the jury as follows:)

THE COURT: Do you want to put something on the record, Ms. Book?

MS. BOOK: Yes. We spoke with Dr. Sikirica's secretary. He can be here at one o'clock today. The way that we are progressing with testimony today, I don't

think it's likely that we are going to get to Dr. Sikirica in all reality. I think I'm going to take until probably the lunch break to finish up Dr. Jenny's direct, if not pretty close to the lunch break, and then we are going to have an hour and a half, if I'm doing my math correctly.

THE COURT: Correct.

MS. BOOK: When we are done. So, I just wanted to see how the Court wanted me to proceed with Dr. Sikirica to be here first thing in the morning for a full day of testimony, or he can be here at 1:00; but he would request, really, to finish today, because he was here for four hours yesterday, and I guess there's a really big backup of bodies at this point. And if he doesn't come here, he's going to go to Kingston to do a bunch of autopsies this afternoon.

THE COURT: Okay. So, what are you asking? We can't go past 2:30 today.

MS. BOOK: No, I know. Can we -- do we want Dr. Sikirica here at 1:00, anyway, or can we send him to Kingston and tell him tomorrow morning because, in all likelihood, we will not get to him at all?

THE COURT: Mr. Coffey?

MR. COFFEY: If I might. I really don't care, except my whole schedule gets tossed away significantly tomorrow. Sikirica is not going to be five minutes. So,

if he goes the entire morning, that creates a real problem for me. I would ask, if you are going to do that, that we start early with him.

THE COURT: Well --

MR. COFFEY: We are accommodating his schedule beyond everybody else's schedule.

THE COURT: I understand. All right. You have some amount of time with Dr. Jenny; correct?

MR. COFFEY: Uh-huh.

THE COURT: So, if you start at one o'clock, you don't anticipate you would be finished in time to then put another witness on before 2:30?

MR. COFFEY: I'm not going to mislead you. I don't know. I can't say. In all honesty, I can't tell you that.

THE COURT: What I would say is you can contact Dr. Sikirica on lunch break when we see where we are with this witness.

MS. BOOK: Okay.

THE COURT: Anything else?

MS. BOOK: No.

MS. EGAN: Yes.

MS. BOOK: Go ahead.

MS. EGAN: There's just been an issue with -- Dr. Leestma has published a new book which is not out in

print yet but is going to come out within, I think, a few weeks. We have requested a copy through defense counsel several times in the past few weeks.

THE COURT: Let me just interrupt. Does this person have anything to do with Dr. Jenny's testimony?

MS. EGAN: It does not, but I just wanted to make a record of it at this point in time.

THE COURT: Well, we are under certain time constraints. So, if it doesn't pertain to this witness -- I'm certainly going to give you a chance to make a record, but I would prefer not to do that right now because we have the jury waiting, and I want to see to it that we at least finish Dr. Jenny's testimony today if possible. So, I will let you make a record at another point in time.

MS. EGAN: Thank you.

THE COURT: We will bring the jury in, please.

COURT OFFICER: All rise. Jury entering.

THE COURT: Okay. Please be seated. The sworn witness remains Carole Jenny. Doctor, I will remind you that you are still under oath. Ms. Book, you may proceed.

MS. BOOK: Thank you, Your Honor.

BY MS. BOOK: (Continuing)

Q. Now, Dr. Jenny, I would like to talk to you about the morning of Sunday, September 21, 2008. Can you tell us what happened to [redacted] that morning?

A. Um, well, he fed, I think, around 4:00 in the morning and was apparently normal; and then at around 9:00, his mother went in and found him barely breathing, not responsive, unconscious, in grave distress.

Q. Okay. And what happened after that?

A. They called 911. He was taken to Good (sic) Samaritan Hospital, where he was resuscitated and put on a ventilator, and then he was transferred to Albany because he needed a higher level of care.

Q. Are you familiar with a differential diagnosis?

A. Yes.

Q. What does that mean, to make a differential diagnosis?

A. That's a list of all the things you consider when you are trying to make a plan for diagnosis and treatment of any patient in any situation. So, you know, in your mind, you would make a list of, you know, what possibly presents looking like this, what are the most likely things, what should be treated first and how should we proceed with a diagnostic workup.

Q. Are you familiar with what Dr. Kardos' differential diagnosis was on the morning of September 21st at Samaritan Hospital?

A. Top on her list was overwhelming sepsis, and she also considered a head injury as a possibility and hypothermia, low

temperature.

Q. Okay. And do you know if dehydration was on there?

A. Yes, it was.

Q. What was done to attempt to treat each one?

A. Well -- in Samaritan Hospital?

Q. Yes.

A. He was given oxygen initially. He was ventilated with a mask and a bag, where they squeeze the bag to help him breathe. He received drugs to keep his blood pressure up and his heart rate up. He received antibiotics, because that's normal when a child comes in that's that age and they are not responsive and they are very ill. They routinely get started on antibiotics because you can't wait for cultures to come back. He was too unstable to do a blood workup. So, they basically resuscitated him, gave him fluids, gave him antibiotics, gave him pressors, which are drugs to keep his blood pressure going, gave him oxygen and put him in an ambulance and sent him to Albany.

Q. Why would a baby be too unstable to get a head injury workup?

A. Well, it takes awhile to get the baby to CT, put him in a scanner. You don't have access to him while he is in a scanner and then bring him back. You can't do that unless their basic level is stable enough, if you don't think you are going to need to do immediate resuscitation. You wait until

you are sure they don't need to be resuscitated immediately before you send them out of the ED or the Intensive Care Unit.

Q. And why was [redacted] not stable enough to go to the CAT scanner at Samaritan Hospital?

A. His temperature was low. His blood pressure was low. He was very ill. He was unresponsive.

Q. At this time, was [redacted] exhibiting any signs or symptoms of sepsis?

A. Yes.

Q. What was he showing?

A. He had low blood pressure, a low white blood cell count. He had a low platelet count, not critically low but lower than normal, and he had low blood pressure and he had trouble maintaining his body temperature.

Q. Now, could these signs and symptoms be associated with anything else?

A. Well, anything that causes shock and DIC, severe trauma, loss of blood.

Q. Could these symptoms be consistent with a head injury?

A. In and of itself alone, the low blood count was not something we would normally see. You can certainly see kids with cardiovascular instability, trouble with their blood pressure and their breathing. Unconsciousness is not uncommon and --

MR. COFFEY: I object to this. She wasn't asked what wasn't. She was asked if something was consistent. I object as nonresponsive.

THE COURT: The objection is sustained. Ms. Book, you can ask a follow-up question.

Q. The signs and symptoms that [redacted] was exhibiting, were any of those symptoms consistent with a head trauma?

A. Some of them were.

Q. Can you tell me which ones?

A. The low blood pressure, the loss of consciousness, the cardiovascular instability, trouble breathing.

Q. What symptoms were not associated with a head injury?

A. The low white blood cell count is something we don't generally see in head injury.

Q. At Samaritan Hospital, was [redacted] showing any signs of a clotting problem?

A. Well, they didn't get clotting studies. They didn't get blood tests for clotting while he was there. He didn't bleed excessively when they put in lines, when they put in IV lines. He didn't have any bruising on his skin or obvious bleeding on his skin.

Q. Okay. Now, when you say that he didn't bleed excessively when they put in IV lines or that he didn't have excessive bruising to his skin, what does that have to do with clotting?

A. Obviously, if you can't clot your blood and you try to start, you poke needles in children's arms and they don't have clotting ability, then they will just keep losing blood; and if their clotting system is reasonably effective, they will not keep losing blood.

Q. So, the fact that [redacted] was not bleeding excessively when hooked up at different IV sites and the fact that he lacked those bruises to his body, did that indicate anything to you about his ability to clot at the time that he was at Samaritan Hospital?

A. Well, functionally, he was clotting reasonably. I don't know if he had abnormal coagulation studies. His platelet count was, I think, 155,000, which is low, but we don't start worrying about kids bleeding out until they get to ten to 15,000.

Q. Okay. Do you know if it was actually 115,000?

A. Oh, I'm not sure. It was over a hundred.

Q. And if someone's platelet count is over 100,000, what does that indicate?

A. Well, they don't have bleeding from blood platelets until it gets much lower. It's lower than usual, but they are not symptomatic at that point, but it's something you watch, obviously.

Q. Okay. And where did [redacted] go from Samaritan Hospital?

A. To Albany Medical Center.

Q. Why did he go there?

A. Because they had an Intensive Care Unit and a neurosurgeon and more -- could offer more intensive care.

Q. Are you aware of whether or not a CAT scan was able to be done at Albany Medical Center?

A. They did.

Q. And are you aware of the results of the CAT scan?

A. Yes.

Q. What were those results?

A. He had old and new subdural hemorrhages.

MR. COFFEY: I object to that, unless she can qualify how she came to that conclusion. There's no evidence in this record that that was a diagnosis at Albany Medical Center and I object to this.

THE COURT: I understand, Mr. Coffey.

MR. COFFEY: I'm sorry.

THE COURT: That's okay. Your objection is sustained.

Q. Are you aware of whether or not [redacted] was suffering from any subdural hematomas at the time that he entered Albany Medical Center?

A. The doctors recorded that in their records.

MR. COFFEY: I object to this. There's no evidence of this.

THE COURT: Well --

MR. COFFEY: May I approach on this or not?

THE COURT: Do you want to approach?

MR. COFFEY: If I can.

THE COURT: You may.

(Sidebar discussion held on the record as follows:)

MR. COFFEY: Judge, there is nothing in this record that any doctor at the Medical Center said that he had a subdural. It is an interpretation, and Waldman went through three hours yesterday talking about his interpretation of that word. Subdural hematoma does not appear in any radiological report; and for her to say that is misleading and it's dishonest on her part.

MS. BOOK: I don't agree with that, Your Honor. Dr. Waldman testified how he would interpret a radiologist's reading of the record. Dr. Waldman did testify that it was, in fact, a subdural hematoma, and Dr. Jenny is aware of the result of the autopsy report which indicated this. So, I feel she is qualified to answer this, and Dr. Waldman's notes from Albany Medical Center say CT bilateral hemispherical --

MR. COFFEY: In that case, it's cumulative. Dr. Waldman already testified to it.

THE COURT: The objections are overruled. The

Court finds it's not unduly cumulative or unduly prejudicial for that reason. Second of all, this witness can testify as to what the records and her review of the records indicated. So, I'm going to overrule the objections, but I'm going to have you ask a new question. You can ask her what her review of the records indicated was the case but -- and as long as you do that, I feel that it's proper. Mr. Coffey, you can certainly cross-examine this witness on that issue regarding your belief that there's no support in the records for what her testimony is going to indicate there is support in the records for. That's the Court's ruling.

MR. FROST: Can I add one thing? I think this is what you were getting at, Judge. I think one of our objections will be or is that this witness shouldn't be allowed to interpret what Dr. Hoover said in his report. Dr. Waldman is different. He can read, but there's no foundation that this witness can read scans herself, as opposed to reading reports. I don't think it's fair to speculate that Dr. Hoover meant X if he said Y.

THE COURT: I understand that point. I don't think we have gotten to that point yet, where that objection would lie, but if we do get to that point and you believe that objection is proper, you can reserve your right to make it and I will consider it.

(Proceedings continue in open court as follows:)

THE COURT: Ms. Book, you may continue.

MS. BOOK: Thank you.

Q. Dr. Jenny, are you aware of what the results were of the CT scan of Albany Medical Center?

A. Yes.

Q. Could you tell us what the results were?

A. The results were that he had excess fluid in his head. They thought it was probably subdural fluid. They hadn't ruled out an enlarged subarachnoid space.

Q. Okay. And was there a hematology consult?

A. There was.

Q. What is a hematologist?

A. That's a doctor that studies blood disorders.

Q. Can you tell us what the results of the hematology consult was?

A. Um, he had clotting abnormalities and a very low white blood cell count, and he was also not making good red blood cells.

Q. Okay.

A. And a low platelet count -- or a dropping platelet count. Sorry.

Q. What is DIC?

A. It's disseminated intravascular coagulation.

Q. What does that mean?

A. That means that something happens that causes the blood to be extra clottable. The blood is stimulated to clot, and when it starts doing that in several different areas, it uses up clotting factors. So, secondarily, you have bleeding problems. So, it's a combination of too much clotting and too much bleeding.

Q. Doctor, are you aware of whether or not DIC can come as a result of head trauma?

A. Yes.

Q. And what is your opinion on that?

A. It's very common. Most of the kids we see with head trauma have DIC in the first couple of days after the event.

Q. And can you explain to us why that is?

A. There's a -- when a child gets a brain injury, there are various chemical substances released into the bloodstream, and one of those is called tissue factor; and tissue factor acts as a trigger to clot, basically, and it can set off a DIC pattern. I mean, there's lots of things that cause DIC; automobile accidents, infections, cancer, head trauma. In our head trauma babies when we studied them, almost all of them had evidence of DIC.

Q. And are you aware of whether or not an ophthalmologist consulted on [redacted]?

A. Yes.

Q. What is an ophthalmologist?

A. A doctor that studies eyes.

Q. And are you aware of what the results were from the ophthalmology study?

A. He had extensive hemorrhaging around the inside of his eyeball, the lining on the inside of the eyeball, called retinal hemorrhages, in multiple layers.

Q. What, if anything, does that indicate to you in your experience?

A. It's a sign of severe problems. In kids, those kinds of hemorrhages are generally only seen in bad head trauma and in severe clotting problems. You can get it in things like sickle cell disease, if it's really bad. You can get it with a direct blow to the eye. That can cause it, as well. But it's unusual in kids to get that extensive of hemorrhaging.

Q. Okay. And can you tell us about -- have any studies been done with respect to inflicted trauma and retinal hemorrhaging?

A. Yes.

Q. Can you tell us about those?

A. Well, there's been lots of studies done, and what they find is that retinal hemorrhaging is very common; severe retinal hemorrhaging is very common in inflicted trauma. A recent study, actually, a nice study was published at Great Ormond Street Hospital, which is a --

MR. COFFEY: Objection, unless it's more than a

recent study. I think it's self-serving.

MS. BOOK: Judge, I think she's trying to identify the study.

THE COURT: The objection is overruled.

A. There was a study at Great Ormond Street Hospital where they looked at all the eyes of kids in Intensive Care, and they didn't look at kids who had trauma, who had abusive trauma, and they found those types of retinal hemorrhages in leukemics, in children with very severe clotting problems. Two children had been in really bad accidents, automobile and so on.

Q. What medical intervention was done at Albany Med on [redacted]?

A. Well, he was kept on a ventilator. He was kept on pressors, which are drugs to keep the blood pressure up. He was essentially brain-dead at the time he arrived. They had said he had -- he had no neurologic function at that point. He was given -- his clotting problems were treated. He was given transfusions. He was transfused with plasma, just plain old plasma that helped his clotting problems. He received platelets. He received red blood cells. He was on routine anti-seizure meds. He was continued on his antibiotics; essentially supportive care until they actually did formal brain death testing and determined that he was not viable.

Q. How is brain death testing performed?

A. Well, there's several different ways. You can do -- in a child that's stable enough, you can do what they call flow studies to see if there's blood circulating through the head. In this case, they did a clinical study, where they take the child off the ventilator and see if his carbon dioxide level goes up in his blood because he's not breathing well. That generally would stimulate somebody to start breathing, and if they see no response, then that's a very bad sign that there isn't any central nervous system function going on.

We also do other things, a neurologic exam, something called calorics, which is putting cold water in the ear to see if the eyes respond. Generally, the eyes will deviate if you put cold water in comatose patient's ears; and then just looking at the reflexes and the general state of neurologic functioning, looking at the EEG's to see if they have any brain waves.

Q. Do you know what the results of the cultures taken at Samaritan Hospital turned out to be?

A. He had one blood culture that was positive for streptococcus pneumoniae.

Q. What is streptococcus pneumoniae?

A. It's a common bacteria that causes -- in kids, it usually causes ear infections. It can cause meningitis. It can cause sepsis. It can cause pneumonia, more commonly pneumonia than meningitis.

Q. How is it that a child can get streptococcus pneumoniae?

A. Well, it's a bacteria that lots of people carry, lots of young children carry. Somehow it gets into their lungs and then into their bloodstream and into their central nervous system.

Q. Now, based on your review of all of the records in this case, as well as all of your years of experience dealing with pediatric patients, do you have an opinion as to how [redacted] could have contracted this streptococcus pneumoniae?

A. You know, sometimes we don't know. Sometimes, it just happens; other times, we assume it comes from --

MR. COFFEY: Object to what she assumes. She already said she doesn't know. I object to anything beyond that as speculation.

THE COURT: Sustained. You can ask a different question, Ms. Book, but the answer can't be based on assumption.

MS. BOOK: I understand, Your Honor. Thank you.

Q. Dr. Jenny, do you have any opinion, specifically as to [redacted] [redacted], as to how he could have contracted streptococcus pneumonia that went into his bloodstream?

A. Well, he had pneumonia in his lungs. I assume that was the original place that it was seeded abnormally; and as it grew, it got into his bloodstream.

Q. Okay. When was [redacted] pronounced dead?

A. I think it was one o'clock or 11:00 on the 23rd of September.

Q. Was there anything further that could have been done for [redacted]?

A. No.

Q. What did the Albany Medical Center doctors feel had caused this baby's death?

A. A head trauma.

Q. Are you familiar, Dr. Jenny, with the brain and its layers?

A. Yes.

Q. Could you step down for us and draw the brain and its layers and explain to us where [redacted]'s head injuries were located?

A. Okay.

MS. BOOK: Your Honor, may I have the witness step down?

THE COURT: Okay.

A. (Drawing) I like to think of the head as an onion because it's in layers. If you look at the head, you have a plane right here, and you are going to look at half the head. You have an outside layer. That's the scalp. It has the hair on it. And under that, you have a skull, which is the brain, a box, such as the bony brain box, and then -- so, here's the

scalp. Here's the skull. And between the brain and the scalp -- I mean the skull and the scalp, you have an area of kind of connective tissue. That's called the -- it's the subgaleal space or below the galea, another word for scalp. So, that's subgaleal. And then right on the very outside of the brain, you have a thin layer of tissue that's a membrane on the -- not a membrane, a thin layer of tissue outside of the skull that kind of feeds the skull and takes care of it, and there's blood cells, blood vessels in that tissue, and that's called a periosteum. Peri, meaning around; and osteum, meaning bone, around the bone. So, it's the layer attached to the bony layer.

And then inside the skull, you have another layer of tissue. In babies, it is very adherent to the skull. It sticks to the skull, and that layer is called the dura, and it's kind of a protective, thick, almost plastic looking membrane that covers the brain. And then inside the dura, there's another layer of tissue, and that is called -- and this is like thin membranes. It almost looks like tissue paper, and that tissue paper layer is called the arachnoid membrane.

And then below the arachnoid, there's another space; and inside that space is the brain. And so -- and there's another tiny little thin layer of tissue that sticks to the brain that kind of we don't -- not really important in terms of making a diagnosis.

So, here's the brain itself; and inside the brain, you have ventricles. Fluid flows through the ventricles, and that fluid goes down to the base of the brain and then circulates within the subarachnoid space. This is the subarachnoid space, meaning it's -- yes. Here's the brain tissue. Here's the arachnoid, the subarachnoid space. And in that space, you have cerebrospinal fluid, which is a clear fluid with sugar and salt in it that floats around and kind of feeds the brain, and it goes inside the brain into these ventricles, into the holes in the middle of the brain and circulates down, goes all the way down to the bottom of the spinal cord. When they do a spinal tap, they are collecting samples of that subarachnoid fluid that's in that particular area.

The other thing that is important in this particular situation is bleeding between the dura and the arachnoid, and that's called subdural bleeding or below the dura, and that's not normal. Kids don't have -- generally, the dura and the arachnoid are right together. There's no space between them. But if something happens - the vessels get broken - then blood can get collected in there. You can also get pus collected in there or other kinds of fluids. But in a healthy, normal state, there's nothing in the subdural space, where there's always fluid flowing along in the subarachnoid space.

Q. Okay. Now, on this diagram, can you show us where

's subdural hematomas were located?

A. Well, it's hard to show on this.

MR. COFFEY: Objection. She hasn't given a foundation on this as to what the basis of this is.

THE COURT: Ms. Book?

MS. BOOK: Your Honor, she testified that she reviewed all the documents in this case, including the autopsy, the results of the CT scan, as well as the Albany Medical records.

THE COURT: The objection is overruled.

Q. Let me do it in a different color, so we can see it.

A. Can I get a new piece of paper?

Q. Sure.

A. (Drawing) So, this would be -- I'm going to draw kind of a cutting through the midline, rather than cutting in this direction. So, here's the nose, the mouth and the face - I'm a terrible artist; I really apologize - and the back of the head and so on. And the brain is -- here's the bottom of the brain box, the bottom of the skull, and it's divided into three compartments. There's a posterior compartment, and then there's a right side, and then there's a membrane down the middle that divides it into a right side and a left side. You basically have right, left and back.

And he had hemorrhaging on the right, up front, up top. On the left, up front, up top, he had some posteriorly

and he had a little bit in this posterior fossa area, and those were subdurals. So, this is just where they were located, not what depth, obviously. So, they were in that subdural space.

He also had -- I think I can show better on the first diagram. He also had some areas of hemorrhage on this periosteal layer. So, he had periosteal bleeds and subgaleal bleeding, which is between the scalp and the skull. So, he had some areas of impact bleeds between the scalp and the skull.

Q. Thank you. Is there anything else that you would like to show on this diagram?

A. No.

Q. You can have a seat. Okay. With respect to what you demonstrated for us, based on your review of the records and [redacted]'s autopsy report, which of what you demonstrated for us was acute?

MR. COFFEY: I object to that as leading.

THE COURT: Overruled.

A. Acutely, he had some acute blood in the subdural space. There was most likely acute bleeding under the scalp outside the skull.

Q. Okay.

A. And also had acute brain swelling, bad brain swelling that developed.

Q. What does acute mean?

A. Means within a day or two; it's right then.

Q. Okay. And where he had the acute subdural hematomas that you described, are they in a place that would have been discovered on that initial ultrasound if they were present then?

A. I think most of the acute blood was posterior. What was present under this part of the head was old blood.

Q. Okay. And where that old blood was, was that at a place that would have been discovered upon that initial ultrasound if it was the result of birth?

A. In my experience, you can see it very well on ultrasound.

MR. COFFEY: I object to that. Her experience doesn't make a difference. It's a question of whether it's reasonable medical certainty.

THE COURT: Overruled.

Q. Okay. So, in your experience, that is the type of injury you would have seen on the ultrasound that was performed on [redacted] on 5/14/08 had it been present then?

A. Yes. We do a lot of ultrasounds on babies whose heads are too big, and the point of that is to see whether there's blood or that cerebrospinal fluid layer is a little extra thick. If there's too much cerebrospinal fluid, that makes the head grow big, which is kind of a common condition that doesn't hurt kids, basically, or whether there's subdural blood on top of that that is, in fact, pressing on the brain

and making the skull expand. So, we get consulted maybe once every two weeks when a child comes in for an ultrasound because of some abnormal head growth, and most of them have just accumulated CSF, the cerebrospinal fluid, and you don't treat it. You don't do anything with it. You say he's going to be fine. His head will be a little bigger than the other kids' heads until he gets to be about two and then -- but the kids that have subdural bleeding, it's much more of a concern.

Q. The subgaleal hemorrhage that you mentioned, can you tell us about that and whether or not that would be something you could see on the outside of [redacted]'s head?

A. Sometimes you can; sometimes you can't. A lot of kids who get blunt trauma to the head will end up with bruising, essentially, on that outside skull membrane in between the scalp and the skull, but they will have nothing externally. They will have no swelling, and we wouldn't even know it was there, unless we pulled back the scalp at autopsy and find the bleeding.

Q. Now, do you know if [redacted] had any external injuries?

A. He did not have any obvious external injury on his skin.

Q. Is that inconsistent with inflicted trauma?

A. No. It happens frequently. The skull is relatively soft and it kind of bends and, so, it doesn't offer a lot of

resistance when a child that age gets an impact injury. And then if you have -- you know, if after the injury, you have very low blood pressure, you are not going to get swelling, because it ain't going to happen because you don't have enough blood pressure to push fluids through your tissues.

Q. In your experience, what are subgaleal bruising? What is that consistent with?

A. Impact injuries.

Q. What do you mean by that?

A. Some object applied to the head or the head hitting an object.

Q. Okay. Are there sutures in the skull?

A. Yes.

Q. What does that mean?

A. Well, babies are born not with a solid brain box. They have plates of bone that are isolated and then held together by cartilage and that's so -- the baby's brain doubles in size during the first year of life. You have to allow for rapid brain growth. If they were born with a fixed skull like an adult has, they wouldn't be able to expand their head to fit that nice growing brain.

And then toward the end of the second year, the head becomes very -- completely calcified but, again, it expands with brain growth. That's normal and that's -- those are called sutures, those cartilaginous pieces. In fact, that soft

spot you feel on a baby's head is where those plates of bone come together, and they don't completely form until maybe seven, eight months of life.

Q. What is cerebral edema?

A. Cerebral edema is swelling, swelling of the brain.

Q. And was that present in [redacted]?

A. Yes, very severely.

Q. Now, you mentioned you also reviewed the autopsy report?

A. Yes.

Q. What findings were listed on the autopsy report?

MR. COFFEY: Objection. We are going to have the pathologist testify.

THE COURT: Overruled.

A. Bleeding between the scalp and the skull, old subdural hemorrhages, new subdural hemorrhages, very swollen brain. He had some, what they call -- what Dr. Sikirica called an infarction or an area of dead tissue in his heart, where from -- that resulted from not getting blood circulated through his heart. He also had some similar lesions in his testicles.

Q. Was there evidence of organ donation?

A. Yes.

Q. What organs were missing?

A. They took part of the liver. They took the -- actually, they took the pancreas. They took the kidneys.

Q. Now, if a baby died from overwhelming septic shock, in your opinion, would these organs have been able to be harvested?

MR. COFFEY: Object to this. There's no foundation.

THE COURT: Sustained.

Q. Dr. Jenny, do you have any experience with children after their death and reviewing the cause of death and whether or not they were, in fact, an organ donor or not?

A. Yes.

Q. And do you have that experience in your thousand or so cases of child fatalities that you have reviewed?

A. Yes. It often comes up.

MR. COFFEY: Object to this as irrelevant.

THE COURT: Overruled. She's attempting to lay the foundation.

A. Um, in the clinical setting, we are involved in cases where the question is is this -- this child, obviously, is going to die; is this a child that's suitable for transplant. And either -- we often have to communicate with the medical examiner to get their permission, and then we also have to communicate with the transplant team about whether they want the organs or not and whether we should press for donation.

Q. So, have you personally been involved in cases where the determination is being made as to whether or not organs are

going to be donated?

A. Yes.

Q. How many times, do you think?

A. Maybe 30.

Q. And of the thousand or so cases that you have reviewed as a part of the death team, do you know whether or not those children were organ donors?

A. Pretty rarely in Rhode Island. It wasn't something that was really emphasized. They did a much better job in Colorado when I worked there in terms of -- one of the District Attorney's kids needed a heart, and they were very liberal about letting us do transplants in medical-legal cases.

Q. Okay. Now, in your experience through what you just described to us, if a baby died from overwhelming septic shock, would you expect that a kidney and a liver could have been harvested to other individuals?

MR. COFFEY: I object to this, foundation. I would like to voir dire on this, at the very least. I object, first of all, without necessity for that.

THE COURT: The objection as to foundation is sustained. At this point in time, we have to break for lunch, in any event. Members of the jury, we will break for one hour at this point in time. We will resume at one o'clock.

During the break, please don't discuss the case.

Do not read or listen to any media accounts of the case. Do not visit any premises mentioned during this trial. Do not conduct any research about this case. Do not request or accept any payment in return for supplying information about this trial. Do not form any judgments or opinions about this case. If anyone attempts to improperly influence you, you must report that directly to me. We will break for one hour for lunch. We will see you back here at one o'clock. Thank you.

(Jury excused.)

THE COURT: Dr. Jenny, I will give you the same admonition that I gave you before, and that is that, given you are giving sworn testimony, please, during this break, don't discuss this case or your testimony with anybody, including the attorneys involved in this case. Thank you. We will see you back here at one o'clock.

MS. BOOK: Your Honor, could we maybe have the Court Officer tell her where she could grab lunch?

THE COURT: Of course.

MS. BOOK: Also, her purse is located in our office.

THE COURT: That's okay. Thank you.

MS. BOOK: Dr. Sikirica, Your Honor, are we okay letting him --

THE COURT: Yes.

MR. COFFEY: Are we going to have Dr. Sikirica here tomorrow morning, or is he going to be somewhere else, like Kingston or some place else?

THE COURT: Do you expect me to be able to answer that?

MR. COFFEY: No, but I would like to find out from the People what his personal schedule is, if he can accommodate us.

THE COURT: We are going to start at ten o'clock tomorrow morning. If Dr. Jenny is finished, then Dr. Sikirica will be the first witness. If Dr. Jenny is not finished, unless you make some arrangements to take a witness out of order, she will finish up in the morning, and I presume Dr. Sikirica would be the People's next and last witness.

MS. BOOK: Correct.

MR. COFFEY: Now, let me ask you this in terms of scheduling. If that's the case, I'm going to ask you to at least potentially consider going a little later tomorrow because now -- I understand your schedule. You can't begin until 10:00, but if Sikirica goes till noon, then I'm pushed over into the afternoon, obviously, and that's a potential problem for me.

THE COURT: Well, I will consider any requests. I can tell you that from OCA's point of view, they won't

even consider a request until four o'clock, so we can advise them exactly where we stand.

MR. COFFEY: Okay.

THE COURT: So, if tomorrow you want to make a request -- I don't represent I will grant it. I represent I will consider it, and we can see --

MR. COFFEY: I'm not blaming you; just, obviously, we are starting to get pushed back here.

THE COURT: We can go off the record and break for lunch.

(Whereupon, a luncheon recess was taken.)

(Proceedings continue outside the presence of the jury as follows:)

THE COURT: Please be seated. Parties ready to proceed?

MS. BOOK: No, Your Honor. May we approach on the record, please?

THE COURT: We are outside the presence of the jury. You can go ahead.

MS. EGAN: With respect to scheduling, Judge, as you know, Dr. Jenny has flown in from Seattle, Washington, to testify today. She is not able to stay overnight and continue her testimony tomorrow morning. She has a caseload of patients waiting for her in Seattle. She needs to fly out tonight if her testimony cannot be

completed today.

That being said, perhaps we could get through the remainder of her testimony, as we have until 2:30. If she cannot complete her testimony, the People are making an application that the remainder of her testimony be permitted via two-way Skype. We are relying on the same cases as the defense has placed in their Order to Show Cause seeking similar relief for -- seeking a similar provision for Patrick Barnes to testify via two-way Skype.

I have not had an opportunity to find out if they are going to oppose this, and Dr. Jenny, because of the time change, would be available to testify starting at 10:00 a.m. until 1:00 p.m. tomorrow via Skype.

THE COURT: All right. Well, first of all, if the Court grants any applications to allow any witnesses to testify via closed circuit T.V., there's no restrictions placed on them. Either the witness is available at that point until completion or the witness isn't. That's the first thing I will say. That applies to the People's witnesses; that applies to the Defendant's witnesses, as well. With that said, Mr. Coffey, what is your position?

MR. COFFEY: I would like to get her going and see where we can end up with this. I certainly don't want -- she's sitting here and -- nonetheless, my

preference, of course, is not to have her end at 2:30 on direct and then I'm forced to now Skype her; but I just as soon we start with her now and see where that takes us.

THE COURT: Let me take a brief recess and see if I can make any changes in my schedule which would allow me to stay past 2:30. Let me do that.

MS. BOOK: Just so you are aware, I have only maybe ten minutes, if that, left on direct.

THE COURT: Mr. Coffey, do you think you have more than an hour? If you do, you do.

MR. COFFEY: Listen, you have been very fair. I'm not just saying that. Let me have you check first, if I can.

THE COURT: All right.

(Brief recess taken.)

THE COURT: We will go on the record. I was able to adjust my schedule such that I can stay here to allow Dr. Jenny to finish her testimony. So, that's what we will do. As soon as her testimony is completed today, I will need to stop for the day, however.

Based upon the application that the People had made, are the People consenting to allowing the defense doctor to testify via Skype or closed circuit T.V.?

MS. EGAN: We are not taking any position on the application at this time, Judge. We only received it last

night. We need to review it in terms of other factors, as well.

THE COURT: Okay. I will allow you to do that but -- I will allow you to do that. Ready to proceed with the jury?

MR. COFFEY: Yes, we are, Your Honor.

MS. BOOK: Yes, Your Honor.

THE COURT: Bring the jury back in, please.

COURT OFFICER: All rise. Jury entering.

THE COURT: Please be seated. All right. Members of the jury, before we continue, as you will recall, I had advised you we would be stopping by 2:30 today. That still may happen, but we are going to stay until we finish this witness' testimony. If that takes us a little past 2:30, contrary to what I said earlier, we will stay at least for as long as it takes to finish this witness' testimony today. So, I just wanted you to be aware of that. The sworn witness does remain Carole Jenny. Doctor, I remind you that you are still under oath. Ms. Book, you may continue whenever you are ready.

MS. BOOK: Thank you, Your Honor.

BY MS. BOOK: (Continuing)

Q. Dr. Jenny, in your experience, have you ever seen a child who died from septic shock organs being donated?

MR. COFFEY: Object to the relevance.

THE COURT: Overruled.

A. Um, you know, I think it varies by institution; but at the institutions I have worked in, that has never been -- that's one of the things; they would not allow it.

MR. COFFEY: I object to this.

THE COURT: Hold on. I have reconsidered the Defendant's objection. As to that question, the objection as to relevance is sustained. Members of the jury, the last question and answer is stricken from the record and is to be disregarded by you.

Q. Now, you mentioned that you reviewed the medical examiner's report. What was the medical examiner's opinion about what caused [redacted]'s death?

A. Trauma to the head.

Q. Okay. And the retinal hemorrhages that you mentioned earlier, are they significant in light of the cause of death?

A. Um, well, certainly, we do see those kind of hemorrhages very frequently in abusive head trauma. You can also see it with severe coagulation disorders.

Q. Okay. The older subdural hematomas, do you have an opinion as to whether or not they were the result of inflicted trauma?

A. Um, given the dating of the subdurals and the fact that the child had normal head growth up until two months of age, I think they occurred after two months of age.

Q. Based on your review of all of the records in this case, based upon your 30 plus years experience in the field of child abuse pediatrics and all of the experience that you have testified to us about with regard to child death and child abuse, do you agree with Dr. Sikirica's finding?

A. Yes.

MR. COFFEY: I object to that.

THE COURT: What basis?

MR. COFFEY: It's cumulative, leading, self-serving, bolstering.

THE COURT: That is an improper question. The objection is sustained.

Q. Dr. Jenny, based upon everything that we have just discussed and your training and experience, do you have an opinion as to what caused [redacted]'s death?

A. Yes.

Q. And what is that?

A. It was abusive head trauma complicated by bacterial sepsis.

Q. And knowing what you know about the mother's condition during pregnancy and her pregnancy complications, does that in any way change your opinion?

A. No. Babies -- well, this baby did very well after birth and in the first four months of life.

Q. Knowing how this child presented at Samaritan

Hospital, all the factors that we talked about earlier as far as the low white blood cell count, the platelets, the blood pressure, everything that we talked about that he presented with at Samaritan Hospital on the 21st, does that change your opinion at all?

A. No.

Q. Why not?

A. Um, well, the types of findings that were found on autopsy are, you know, clearly related to trauma, multiple episodes of trauma, and the acute nature of his decompensating, you know, going from -- is also concerning for trauma; and his blood work, much of it is very consistent with trauma, and his low white count, his positive blood culture, are consistent with an infection.

Q. Do you have an opinion about how this child could have gotten the infection in light of the head trauma?

A. Um, kids with chronic head trauma do -- are more susceptible to lots of medical illnesses in terms of, you know, the -- but I can't say that the head trauma caused the sepsis, no.

Q. Okay. What do you mean that kids with head trauma are more susceptible?

MR. COFFEY: Objection. If she can't give an opinion, she can't give an opinion. So, anything else, I think, is outside the realm of her expertise.

THE COURT: Ms. Book?

MS. BOOK: Your Honor, she said that she couldn't say specifically with [redacted], but she did say that, based on her experience, that children with trauma are more susceptible to other types of diseases, and I would like to explore that with her.

THE COURT: Well, if she indicated that she couldn't say with respect to this particular person, that's all that is relevant here. So, I'm going to sustain the objection.

Q. Dr. Jenny, what is aspiration?

A. It is when foreign material gets into the airways and moves down into the lungs and causes inflammation in the lungs.

Q. How can aspiration happen?

A. Um -- well, some babies are born with it. Others, you know, do fine, and then they have some kind of bad illness or they get paralyzed muscles or they get a bad head injury and then their swallowing mechanism becomes inefficient and material gets into the lungs.

Q. Now, with respect to aspiration, is that something that would have to occur during a feed?

A. No. It can occur during a feed. It can occur if the baby burps. It can occur -- we can aspirate secretions from the mouth at any time.

Q. So, can you aspirate on your own spit or on your own

spit-up?

A. Yes.

Q. When you -- say I swallowed something down the wrong pipe. Is that kind of akin to aspiration?

A. Yes.

Q. Knowing what you know about [redacted] likely also having sepsis present at Samaritan Hospital, at Albany Medical Center and upon findings on autopsy, does that in any way change your opinion that [redacted] died as a result of head trauma?

A. No.

Q. Why not?

A. Well, because he had acute head trauma at autopsy, and he had all the signs and symptoms of acute head trauma.

Q. Is it likely that a child who is beyond the point of medical intervention at 9:00 a.m. due to overwhelming septic shock would have taken a bottle at 3:00 or 4:00 in the morning?

MR. COFFEY: Object to this, unless she's qualified to testify.

THE COURT: Sustained.

Q. Dr. Jenny, do you know, based on your training and experience and your experience with sepsis, whether a child who is beyond the point of medical intervention at 9:00 a.m. due to overwhelming septic shock would have taken a bottle at 3:00 or 4:00 in the morning?

A. Yes.

Q. And what is that answer?

A. Well, I think it would depend on the organism. If it's pneumococcus, the kids are generally sick for a couple days before they collapse. If it's another bug called meningococcus, they can die very quickly.

MR. COFFEY: Objection, unless she can relate it to this case.

MS. BOOK: That's fine, Your Honor. I will move on.

THE COURT: Okay. The objection is sustained.

Q. Would a head injury ravage an infant in a matter of hours to the point of no return?

A. Yes.

Q. How so?

A. Well, it would depend on the nature and severity of the injury or if it's a repetitive injury, because we know that the response to a second or third or fourth injury is much more dramatic and much more devastating than the response to the first injury, when the kids are injured more than one time.

Q. Can you relate this to [redacted]'s case at all?

A. Well, he had old trauma and obvious signs of new trauma. He had old bruises under his scalp and new bruising under his scalp, old subdurals and new subdurals. So, he clearly had more than one episode of impact to his head.

Q. Do you have an expert medical opinion to a reasonable degree of medical certainty as to whether or not the subdural hematomas found on autopsy were present at birth?

A. In my opinion, they were not.

Q. Why is that?

A. Because when we see kids that have continually growing subdurals from birth, their heads start growing immediately and they expand fairly dramatically, and this child had normal head growth. So, there really wasn't any room for extra fluid at two months of age.

MS. BOOK: May I have one moment, Your Honor?

THE COURT: You may.

Q. Doctor, if I told you that there's been testimony in this trial that the Defendant, Mr. [redacted], had a fight with his wife, was angry; [redacted] was crying and that he bounced the baby onto the bed. He didn't stop crying, so he bounced the baby onto the bed harder and the baby fell onto the floor; and I gave you further information that this bed was a king size bed on just two box springs, only 17 inches up off of the ground, not on any sort of a bed frame or headboard type elevation. And seeing the Defendant here in court, do you have an opinion, to a reasonable degree of medical certainty, whether or not [redacted]'s injuries could have occurred from this?

MR. COFFEY: I object to this as lack of

foundation.

THE COURT: Sustained.

MS. BOOK: Your Honor, may I ask from the Court what foundation you would like me to --

THE COURT: Well, I don't think any foundation has been laid that this witness has any expertise in determining the mechanism of injuries and what type of actions or trauma, if that's the case, would cause what type of injuries.

MS. BOOK: Your Honor, the witness did testify - and I can expand on this if Your Honor would like - that she worked with a lab in Japan for five years. The sole purpose of their studies was to look at mechanisms of injuries with test dummies and babies to look at inflicted traumas, to look at falls, to look at automobile crashes and to watch those -- to see how those types of injuries occurred.

THE COURT: I do recall that testimony, but I'm not certain it rises to the level of setting the appropriate foundation. If you want to attempt to lay a further foundation, you may do so at this time; but at least for the present purpose or for the present time, I should say, the objection as to lack of foundation is sustained.

Q. Dr. Jenny, do you have any experience throughout your

30 years in child abuse pediatrics with taking a history and then being able to see corresponding trauma to the child?

A. Yes.

Q. Can you tell us about that?

A. Well, that's part of the workup. That's what -- that's what we do in my field, because the big question is always does the injury match the history that's given; and, so, that's a very important part of thousands of cases that I have done.

Q. You also mentioned that you did work in Japan with respect to trauma on -- as well as automobile accidents, etc., on crash test dummies, children and babies. Can you tell us more about that work and your findings?

A. Well, again, we acted out many injury scenarios in the laboratory with the babies very -- completely wired with accelerometers, string gauges, and all of this was videotaped on high speed video; and then we analyzed that data with respect to the kinds of injury, events that happened, both accidentally and inflicted injuries.

Q. And do you have experience with acceleration/deceleration type injuries in your years of experience?

A. Yes.

Q. What is an acceleration/deceleration type injury?

A. Well, there's different types. There's what we call

linear acceleration, where the head just moves very rapidly in one direction; and then there's annular acceleration, where the head flops and flips back and forth once, twice, however many times. So, most injuries have a component of both, because when the kids -- if you hit something and you rebound, your head swings. When you hit a hard surface, the head swings. So, you get linear acceleration when you hit the hard surface and annular acceleration when you go back.

Q. And what exactly goes on inside of the head when there is an acceleration/deceleration type injury?

A. Well, you get strain on the brain tissue. You essentially get displacement and strain of the brain tissue itself, and you get -- the brain moves in the head and you get tearing of the little delicate vessels that run through that subdural space around the brain.

Q. So, does that have to come from a shaking?

MR. COFFEY: May I voir dire before -- if she's being qualified? Let me do this before -- let me withhold that objection for a minute.

THE COURT: Okay.

Q. Does that have to come from a shaking?

A. No. It can come from either an impact or a shaking injury.

Q. What about an impact on a soft surface?

A. Well, it depends on how much rotation the child has,

how firm the impact was, how firm the surface is. It varies.

Q. What about the distance that the child would have traveled in the air into that surface? Would that matter?

A. Well, the further the distance, the worse the impact is going to be.

Q. Would the age, size and vulnerability of the child come into play?

A. Yes.

Q. Why is that?

A. Infants respond to head trauma very differently than adults. They have more complicating factors. They have -- they are more likely, with an episode of head trauma, to have trouble breathing afterwards because their ability to regulate their heart rate and respiratory rate is very immature. They often have a period of profound low blood pressure in their heads after an impact or a rotation injury because, again, the mechanisms of regulation are not mature, so they can't respond quickly. After they have an injury, the amount of damage that is done is much more extreme than an adult or an older child. And I can tell you why that is if that would be helpful.

Q. Yes. Please tell us why that is.

A. When infants are born --

MR. COFFEY: I object. This is not relevant, the issue of the biomechanics of this.

THE COURT: The objection is overruled.

A. When infants are born, they have many extra brain cells - or axons, actually - protuberances from brain cells they don't need. These are just the things that go from the brain cell to another brain cell to make connections, and they are born with a lot of them, and then they -- the ones they don't use die. So, strangely enough, even though their brains are growing, the number of cells actually decreases in the first year of life, and that's a normal process. You know, they were designed that way, I guess, to get rid of the excess noise and make the brain more efficient.

But all of the machinery that you need inside the brain cell to destroy the brain cell is already there and working, because it's going through this process. So, you have these energy packets that have enzymes in them and they are very ramped up in the first year of life. So, when the brain suffers an insult and starts to die, the response is much more dramatic.

So, we measure that in a couple of different ways. One is we measure chemicals that get released from a damaged brain that are toxic in the bloodstream; and after an injury, infants' levels go sky high compared to adults and older children. And, so, that's an indication of the brain essentially injuring itself after the initial injury.

So, you have normal healthy cells next to one that just got damaged; and as that cell dies, it releases substances

that kill the cell next door, that kill the cell next door, that kill the cell next door, and that process is really ramped up and active because of the way their brains are constructed to get rid of unnecessary neurons.

Q. Now, based upon everything that you just told us, do you have an expert medical opinion, based upon the scenario I gave you of the Defendant bouncing a baby onto a mattress 17 inches off of the ground, bouncing him again harder, the baby falling onto the ground, as to whether or not this could have caused [redacted]'s injuries?

MR. COFFEY: May I voir dire now?

THE COURT: Yes, you may.

VOIR DIRE EXAMINATION

BY MR. COFFEY:

Q. Doctor, good afternoon.

A. Good afternoon.

Q. Didn't you tell us before that, with regard to that hypothetical, there's a number of variables that you would have to know; correct?

A. Um, yeah. You would have to know --

Q. The question is: Did you tell us that? I'm not asking for anything else, Doctor.

A. Yes.

Q. You testified -- I'm sorry. You don't know the surface; do you?

A. No.

Q. You don't know where the baby was dropped; do you?

A. He was dropped vertically in the description that was given.

Q. Really? You don't know if he was -- he could have been dropped horizontally. You don't know that; do you?

THE COURT: Mr. Coffey, this doesn't go to the issue of foundation. You can save these questions for cross-examination.

Q. Sorry. Doctor, you have testified -- you are not a biomechanical engineer; are you?

A. I'm not.

Q. And you have testified, in fact, previously as a result of this matter that you can't give an opinion on the amount of forces that would interact upon a child in terms of trauma; that you are not able to give that opinion? Isn't that true?

A. Well, there is no --

Q. Isn't that true, Doctor, or is it not true?

MS. BOOK: Your Honor, I object and ask that the witness be allowed to answer the question.

THE COURT: You have asked your question. The witness can answer as she sees fit.

A. We don't know the injury thresholds in terms of the amount of G-forces or rotational forces it takes to cause

injury. That's never been established for infants. We do have a lot of experience with accidental and nonaccidental injuries that tell us -- that give us some parameters for how much is too much.

MR. COFFEY: I object to her testimony. There's no foundation based upon her concession.

THE COURT: Ms. Book?

MS. BOOK: Your Honor, I believe that everything Dr. Jenny has laid out, her extensive studying of trauma and forces in Japan, as well as her extensive experience with head trauma, taking histories of patients, being able to look at that, look at corresponding injuries, that Dr. Jenny is qualified to give an opinion on this.

THE COURT: I haven't heard -- I have heard all of that testimony, but I haven't heard any foundation laid as to whether this witness has any experience concerning the mechanisms of certain types of injuries and the resulting injuries. So, the objection as to foundation is still sustained at this point in time.

DIRECT EXAMINATION

BY MS. BOOK: (Continuing)

Q. Doctor, have you tested different types of events and the occurrences that come of it? Does that make sense?

A. Yes.

Q. And in what respects?

A. Well, I mean, in two ways. One is by looking at thousands of head injuries and other injuries and looking at the histories that are given and, you know, making conclusions on the reasonableness, you know, compared to all the other injuries we see, many of which are witnessed; and you reach conclusions about types of injuries that result from those types of events.

And then we studied, you know, the biomechanical parameters in a laboratory, but the problem is that was a crash test dummy. That wasn't a baby that would die or not die or get comatose. So, that research is different than experiential observations in the clinical setting.

Q. Okay. And have you been able to make correlations between the mechanism of injury and the end result?

A. Yes.

Q. What types of conclusions have you been able to reach?

A. Um, with impact injuries, you see things like subgaleal hemorrhages, for instance. You can see subdurals with both the impact and rotational injuries. Coma results from -- mostly from rotation of the head, and that's well established in the laboratory in many, many settings. So, you can look at injuries and make a reasonable analysis as to the severity in terms of what the clinical outcome will be.

Q. And have you practiced this in your experience over

the last 30 years?

A. Yes.

Q. In what ways have you practiced this?

A. Well, we get lots and lots of histories, and we often also see -- I see every accidental head injury in a child under two and many of them over two at our hospital. So, if we know a child has been in an automobile accident or had a particular type of fall, we can then look at the types of injuries that they get. So, I have had a lot of experience with accidental injuries and inflicted injuries and particularly this age group, particularly in the under ones.

Q. Okay. Now, in your expert medical opinion, if the Defendant bounced [redacted] [redacted], as you knew him to be, at four months old onto a bed; he didn't stop crying, so he bounced him harder, fell onto the floor, stopped crying at that point, do you have an opinion, to a reasonable degree of medical certainty, if that could have been the cause of [redacted] [redacted]' injuries?

MR. COFFEY: I object to this.

THE COURT: Okay. The proper foundation has now been laid for this witness to testify. However, the form of that question is improper. So, the Court will sustain the objection as to the form of that question.

Q. Do you have an opinion, to a reasonable degree of medical certainty, whether or not [redacted] [redacted]' injuries

could have been as a result of what I just described to you?

A. The acute but not the chronic, obviously.

Q. Okay. And how could the acute have been the result of that?

A. The acute bruises on the scalp, the acute bleeding in his head.

Q. How is it that that type of action would cause that type of injury?

A. Both impact and rotation.

Q. How would that involve both impact and rotation?

A. Well, again, you would have impact on a softer surface with a bounce. You would have multiple episodes in a row, and you have had impact on a hard surface, again, and you usually get rotation with impact on a hard surface. You always get rotation with impact on a hard surface.

Q. The fact that he didn't have any corresponding outside head trauma, is that consistent or not consistent with the history I just gave to you?

A. That's something we see very commonly. It's very consistent; that you see the bleeding and the bruising under the scalp, not outside the scalp.

Q. Is there any particular reason in this case why it would be consistent?

A. Well, again, you know, him being so hypotensive, having such low blood pressure, he wouldn't be perfusing his

tissues well. To get that swelling, you have to have blood flowing through the vessels.

Q. Dr. Jenny, can you tell us, to a reasonable degree of medical certainty, whether or not you believe that [redacted]' injuries came from an inflicted trauma?

MR. COFFEY: She's testified to this four times now. I object. I may be off one more or one less, but nonetheless, I object.

THE COURT: This has been asked and answered. The objection is sustained.

MS. BOOK: May I have one moment?

THE COURT: You may.

MS. BOOK: I have nothing further. Thank you.

THE COURT: Mr. Coffey?

MR. COFFEY: Thank you.

CROSS-EXAMINATION

BY MR. COFFEY:

Q. Tell me, Doctor, do you care about history?

A. Do I care about history?

Q. Yes. You repeated my question. Do you care about history?

A. History in a patient setting, history in a historical setting?

Q. Doctor, we are not talking about a historical setting. We are talking about this case.

A. Yes, okay. In all cases, yes, I care about history.
Q. You do?
A. Yes.
Q. And you have testified, I think, on four occasions for this office; correct?
A. Yes, I think so.
Q. Well, your recollection is better than mine. Could it be more than four?
A. I don't think so.
Q. And on how many different cases have you testified?
A. Three.
Q. And how much money did you make from this office?
A. I don't know.
Q. Come on, Doctor. You can add it up. You know what --
A. I don't keep records. I mean, I don't keep the records. My husband does. This was years ago. I don't know how much I made.
Q. With all your experience, all the things you told us about, when it comes to money, you don't keep track. Is that what you are telling me?
A. I don't handle it.
Q. That's not my question. I didn't ask if you handled it.
A. My husband, I would assume, handled it.

Q. I don't handle it, either, but my wife knows -- I know what's going on, so --

A. I don't remember the specific amounts that I charged in these trials.

Q. Now, let me go back to history for a moment. If you had a choice, Doctor, just generally speaking - let's talk about generalities - between taking a history given by a mother, who is, by the way, not claimed to have done anything wrong, or a person who was been convicted of four felonies and 14 misdemeanors, on balance, who would you tend to support?

A. Most of the time, if the mother has not been the abuser, their history is accurate.

Q. The answer, then, is the mother; right?

A. Yes.

Q. Correct?

A. Yes.

Q. So, Wilhemina Hicks -- you know who she is; right?

A. The mother of this child.

Q. And I assume you have spoken to her?

A. No. Have I spoken to her? No, I haven't.

Q. Well, isn't it important to talk to the parent about a child? You have done that; right?

A. I have read all the interviews and I have read the material in the medical record. I haven't directly spoken with her.

Q. I know what you haven't done. I'm more interested in what you have done. Have you talked to the mother?

A. No.

Q. And the mother would be a valid historian; correct?

A. I assume.

Q. Well, it's interesting, because a number of facts that you have been given today were submitted by the mother. You are aware of that; correct?

A. I have submitted facts that were in the medical history and in the interviews that were recorded contemporaneously.

Q. From the mother?

A. Yes. She was one of the people that gave information.

Q. Now, in terms of this -- tell me something. You travel around the country testifying for District Attorneys; don't you?

A. Um, I do this once every month or two.

Q. Okay. Well, that makes anywhere from six to 12 a year; right?

A. Not 12. I would say I probably testify more like four or five.

Q. Four or five?

A. Yes.

Q. Well, we have gone from once or twice a month to four

or five a year. Somehow, that doesn't add up to me. Once or twice a month goes 12 to 20 -- is six to 12?

A. I'm sorry. I was mistaken about once or twice a month. I testify once or twice a month, but most of my testimony is local.

Q. I'm sorry. You testify once or twice a month. And you testify all over the country; right?

A. I have testified in different jurisdictions, yes.

Q. Is the answer to that yes?

A. Yes. I don't know what all over the country means. I have testified in several different states.

Q. Let me take the geographic area. Let's take the West Coast of the United States. You've testified in the West Coast; right?

A. Yes. I live on the West Coast.

Q. I didn't ask where you lived. I asked where you testified.

A. I have testified. That's home base.

Q. You have testified in the South; right?

A. Once or twice.

Q. The answer is yes?

A. Yes.

Q. You have testified in the Midwest?

A. Chicago, yes.

Q. Well, maybe that's on the West Coast but --

A. No, in Chicago, I testified.
Q. You testified in the East?
A. Well, I lived there for 17 years, yes.
Q. Okay. You have testified all over the country; right?
A. Yeah. I haven't testified in every state in the country.
Q. Okay.
A. It depends on how you define --
Q. If I don't ask you the exact question, then we are going to have a little argument; aren't we? In other words, when I asked you if you testified all over the country and you said you don't know what that means --
A. I would define that as the entire country. That's the way I define it. Maybe I'm defining it differently.
Q. In how many states do you think you have testified in the country on behalf of the District Attorneys or Federal prosecutors? What's your best --
A. I think 17.
Q. Seventeen?
A. Yes.
Q. And Doctor, in terms of your testimony, you have claimed you have written a book that you say is the most authoritative in the field; right?
A. I didn't say that. I think it's a very good book. I

didn't say that.

Q. Now, in terms of what you do, you were in the American Professional Society on the Abuse of Children; right?

A. Yes.

Q. That very term indicates that the professionals there are concerned about the abuse of children; right?

A. That's right, yes.

Q. You are a member of the International Professional Society on the Prevention of Abuse For Children; correct?

A. Yes.

Q. You have spoken -- and I'm going to use the word 50. You have spoken over 50 times around the country to various prosecutorial authorities with regard to suspected child abuse; haven't you?

A. I have testified or lectured?

Q. Lectured. I apologize.

A. No.

Q. Twenty-five?

A. I don't know. I would have to look at my CV.

Q. Does your husband take care of that, as well?

A. No. I --

MS. BOOK: Objection.

THE COURT: Sustained. You don't have to answer that question.

Q. So, with regard to the money and with regard to the

number of times you have lectured, you can't tell this jury; correct?

A. I can't without looking at the count and say that it's accurate.

Q. Did you think I was going to ask you these questions?

A. I didn't know what you were going to ask me.

Q. You had no idea what I was going to ask you?

MS. BOOK: I object to the relevancy, Your Honor.

THE COURT: Sustained.

Q. Now, Doctor, with regard to the District Attorneys, how much money did you make last year testifying for prosecutors?

A. About $70,000.

Q. Seven or 70?

A. Seventy.

Q. Seventy?

A. Yes.

Q. And you were paid at that time as a professor at Brown?

A. Yes.

Q. And how much have you made so far this year?

A. I don't know. I don't know. I didn't work from August to February. I took -- that's when I was retired. So, I did more court work than usual. So, I don't know. I haven't

counted it up.

Q. How much do you charge to testify today?

A. $3,000 if it's a whole day.

Q. This is a whole day, I assume?

A. Yes. I assume, yes. It will be by the time I get home.

Q. And how much did you charge to review the records?

A. I think I have done about eight hours.

Q. All right. And how much do you charge an hour?

A. $300 an hour.

Q. That's 5400 on this case alone?

A. Eight times three is 24.

Q. Well --

A. Plus three.

Q. Let's not forget the three grand we are getting paid, Doctor; right?

A. That's right, yes.

Q. Now, how many times have you testified in the last year?

A. I don't know.

Q. Now, in terms of your -- and you made a point of being -- testifying on both sides, prosecution and defense. In fact, your practice is overwhelmingly testifying on behalf of prosecutors, such as in this case; correct?

A. Of the cases that I review, I'm more often asked to

testify by prosecutors.

Q. It is overwhelming the percentage. In fact, it's 90 percent or more; isn't it?

A. Yeah. That's fair, yes.

Q. Those are your words, 90 percent. I didn't come up with that. You said that; right?

A. I don't remember.

Q. Did you read your -- you have given testimony in this matter. Have you read your testimony?

A. No.

Q. Have you talked to the prosecutors in this case?

A. Yes.

Q. When was the last time you talked to them?

A. We had dinner last night.

Q. They have must have gone over your testimony with you?

A. In my -- my previous testimony or this testimony?

Q. Whatever.

A. We talked about what this case, this most recent -- you know, what's coming up tomorrow is what we talked about.

Q. Yeah. And didn't you ask to see what have I testified to previously? Didn't you ask to see that?

A. Um, I think they sent it to me. I don't think I had time to go over it.

Q. When were you first told about this trial?

A. Well, I was expecting it was going to be in a couple of weeks.

Q. When were you first told about the trial?

A. Oh, not too long ago, actually. I can't remember.

Q. Well, that's another thing you can't remember?

A. That's right. I don't know the date.

Q. Well, was it within the last two months?

A. Probably, yes.

Q. Well, you had ample time in the last two months to read any testimony you have given; correct?

A. Well, I had a lot of things to do in the last two months. So, no, I haven't read it.

Q. Now, you told us, I think, that you were at Brown University, and you now moved from Brown back to Seattle. That's your hometown, Seattle?

A. Yes.

Q. Initially, you were in Colorado; correct?

A. Yes.

Q. And you left Colorado under rather unpleasant circumstances; didn't you?

A. Well, I got offered a job that paid twice as much money at Brown. I was offered the first tenured professorship at Brown, or in my field at Brown, and my husband got offered a fabulous job, too. So, I thought it was actually a wonderful move.

Q. Well, actually, when you have left Colorado, you were in the middle of a lawsuit; weren't you?

A. I don't think so. I don't remember. No.

Q. You weren't involved, you and members of your staff involved in a malpractice suit when you were in Colorado?

A. I have been sued five times, but nobody has ever won.

Q. Okay. Now, let me talk about what you reviewed here in this case. I think you told us you reviewed the medical records; correct?

A. Yes.

Q. You reviewed the -- well, the medical records at Samaritan, Seton Health, Albany Medical Center; right?

A. Yes.

Q. And you read the autopsy report; correct?

A. Yes.

Q. Now, we haven't heard about your connection with Dr. Sikirica, which is somewhat closer than -- and I'm not saying it's elicit, but your relationship with Dr. Sikirica is not distant; is it? You know him very well?

A. Well, he used to work in Rhode Island. He worked there for several years before he came here.

Q. Well, Rhode Island is a big state. When he worked in Rhode Island, he worked for you; didn't he?

A. He didn't work for me, no. He worked for the Medical Examiner's Office.

Q. Well, you knew him; right?

A. Yes. I did cases with him. I didn't socialize with him.

Q. I didn't ask if you socialized with him. I asked if you knew him.

A. Yes. I know him.

Q. And you know him on a first name basis?

A. What is his first -- I always just called him Dr. Sikirica. I honestly don't know his first name.

Q. Have you talked to Dr. Sikirica about this case?

A. I did several years ago.

Q. So, the answer is yes?

A. Yes.

Q. And you talked to Dr. Sikirica, I presume, because you wanted to find out his opinion and his thoughts; correct?

A. Yes. We did talk about the case, yes.

Q. Correct?

A. Yes.

Q. Now, let's talk about some of the people that would be important to talk to. Do you know Dr. Waldman?

A. No.

Q. Do you know who he is?

A. No.

Q. Dr. Waldman testified yesterday. He is a neurosurgeon. Now, have you ever read anything that Dr.

Waldman has said about this case?

A. I read the medical records. I didn't memorize them. I don't know the names of all the doctors that were involved.

Q. Well, do you know who the primary doctor for [redacted] at Albany Medical Center was?

A. I think it was Dr. Edge.

Q. Dr. Edge. And who is Dr. Edge?

A. He's an intensivist.

Q. And Dr. Edge, as you go through those records, Dr. Edge, he is the treating physician. His name appears all throughout those records; correct?

A. Right.

Q. He is the person who would have been on the front lines of this case; correct?

A. Yes.

Q. He's the person that, if you wanted to know what was going on with this child when the child came to the hospital, Dr. Edge would be in the best position to tell us; wouldn't he?

A. Well, I certainly reviewed all of his notes very carefully.

Q. I didn't ask you that. I asked you if he would be in the best position to know what was going on with that child. Would he?

A. I actually think that you are better off looking at the entire summary of the medical chart, not just focusing on

one doctor.

Q. Wouldn't he be in the best position, even with all of those records?

A. Probably the --

MS. BOOK: Asked and answered, Your Honor.

A. Probably the --

THE COURT: Overruled.

Q. Wouldn't he?

A. Probably the resident or intern who was with the kid, you know, 24/7 would have a better knowledge of what happened minute to minute and hour to hour, especially this many years later. Without the medical record, I think most physicians wouldn't remember much about a case.

Q. You don't know -- in other words, you don't even know what connection Dr. Edge had with this baby; right?

A. He would make attending notes. The resident would write up a note and then he would make an attending note.

Q. Right. He would sign off on it; right?

A. Once a day, yes.

Q. So, let's not start putting everything off on the resident. The fact of the matter is, Doctor - and you told us how you are board certified - when you are an attending physician in a hospital and the baby comes in, that is your responsibility; isn't it?

A. Yes, it is.

Q. I don't care what the resident does. That resident could be good or bad, whatever. You sign off on something in a hospital record, your name is on it, you are responsible for it; correct?

A. That's right.

Q. You are telling the world and other medical professionals, "This is what I see. This is what I have heard. This is my diagnosis," and so forth; correct?

A. Right.

Q. And that is exactly what Edge did in this case; right?

A. Yes, he did.

Q. He would be the person where the buck would stop; right?

A. He was responsible as the attending physician, yes.

Q. Did you talk to Dr. Edge?

A. No, I didn't.

Q. Doctor, with regard to aging a hematoma, you are not qualified to do that; are you?

A. No, I'm not. Our imaging studies are done by neuropathology.

Q. And in fact, if you want to age a hematoma, you wouldn't go to a gynecologist; would you?

A. No.

Q. You wouldn't go to an obstetrician; right?

A. No.

Q. You wouldn't go to a -- you wouldn't even go -- in terms of that, even a pathologist would not be the person that you would necessarily go to; right?

A. That's something that they do, but the neuropathologist is usually the final word on that.

Q. Right. So, I assume, then, that you would have, in terms of your opinion, gone to talk to Dr. Hoover, who, as you know, issued a report in this case; right? Let me show you.

A. I'm not sure I saw the report.

Q. You don't think you saw the report?

A. I don't remember the name. I'm sorry.

Q. Let me show you what is called People's Exhibit 15. That is a neuroradiological report issued by a board certified neuroradiologist at Albany Medical Center Hospital.

A. Well, it's an ultrasound. That would be surprising, I guess, because they usually don't do ultrasounds.

Q. Did I give you the wrong -- I apologize. I'm sorry, Doctor. I apologize for that.

(Albany Medical Records marked Defendant's Exhibit D for identification.)

MR. COFFEY: Judge, I'm going to offer the certified records of the Albany Medical Center Hospital.

THE COURT: Can I have a date?

MR. COFFEY: Yes, who came into the care and

treatment of [redacted] on September of 2008.

THE COURT: Ms. Book?

MS. BOOK: No objection.

THE COURT: Defendant's D will be received in evidence at this time without objection.

(Defendant's Exhibit D marked for identification received in evidence and marked Defendant's Exhibit D in evidence.)

Q. Doctor, I'm going to move on. When I find what I'm looking for, I will talk to you about that. Now, you have previously expressed the opinion that on aging a subdural, assuming there is a subdural, that you would defer to a radiologist; correct?

A. In terms of -- if I had a CT or an MRI, I would ask a radiologist to tell me what they see.

Q. Okay. Now, so, if I were to say to you -- or ask you, rather - I'm sorry - the age of a subdural, if it were a week or two weeks or a month, your answer would be, and has been in the past, I would defer to the radiologist?

A. Well, I -- what I generally do in all cases is consult with radiology. If it's my kids, I have seen them in the hospital and I -- it would depend on radiologic reports and medical records that I review.

Q. Is the answer that you would defer to the radiologist or no?

A. I wouldn't do it on my own.

Q. And in fact, dating a subdural is a very complex science; isn't it?

A. It's complex, yes; and by radiology, it's rather inexact.

Q. Well, it's very complex. You used the phrase very complex; haven't you?

A. Well, it's complex because it's inexact. We don't have very good baseline data on aging subdurals in infants. All the data comes from old people.

Q. So, if it's complex for radiologists, it's even more complex dating it for a pathologist; isn't it?

A. Well, they have an advantage, I think, because they have the material right in front of them.

Q. Except -- I'm sorry. Go ahead.

A. A pathologist can look at it under the microscope. He can look at well-defined changes. Again, there's not been many studies done on the aging of subdurals in babies. But according to some people, it shouldn't be much different than the aging of subdurals in older people.

Q. Doctor, let's go back to my question. You have testified probably hundreds of times; correct?

A. Yes.

Q. My question to you is: In dating a subdural, you would rely upon a radiologist more so than a pathologist; correct?

A. No. I would think that the pathologist, if the patient died, would have a better handle on what they are actually seeing.

Q. Do you recall testifying in the case of Jennifer Delbreck (phonetic) versus Melody Hewitt in Chicago in a federal court in 2013?

A. Yes.

Q. Do you recall that testimony?

A. I don't recall it but -- I mean I recall testifying. I haven't read the testimony.

Q. Were you criticized by the federal judge in that case?

A. He disagreed with me.

Q. Well, maybe he didn't criticize you. He disagreed with you?

A. I was told that it wasn't critical. It was just a disagreement.

Q. This is Page 1155. "Question" -- this is, by the way, this is January of 2013, about a year and a half ago. So, I'm going to ask if you recall being asked this question:

"Question: Would you agree with -- do you agree with him that the chronic subdural hematoma was two weeks or greater in age at the time she was admitted to the hospital on 12/28?

"I would leave that to the radiologist. Dating subdurals is a very complex science and that's -- pediatricians

depend on what the radiologists tell them, so I would leave that for him to decide."

A. But your question was pathologist versus radiologist.

Q. Doctor, stop for a minute. Do you remember being asked that question and giving --

MS. BOOK: Objection, Your Honor.

THE COURT: Mr. Coffey?

MR. COFFEY: I'm sorry, Judge. But she --

THE COURT: Hold on a minute.

MR. COFFEY: Sorry, sorry.

THE COURT: Don't speak that way to the witness. Ask her a question, allow her to answer.

Q. My question is: Do you recall being asked those questions and giving those answers?

A. I don't recall it, but that's an answer I would give.

Q. You didn't say anything about a pathologist there; did you?

A. No, you did. You asked me a question, would I depend more on the pathologist or the radiologist, and I said I would depend more on the pathologist. That's what the question was that was asked.

Q. Doctor, in Chicago in 2013, when asked of aging subdurals, you told the Court, under oath in a federal case, that you would rely upon radiologists. That's what you said?

A. More than pediatricians in dating subdurals.

Q. I'm sorry. What?

A. More than pediatricians in dating subdurals. Your question was do you rely more on the pathologist or the radiologist, and I would say, in that order, pathologist would have the best data, the radiologist the next, and the pediatricians depend on the data that is interpreted by those other two specialties. But, certainly, somebody who actually opens up a head and looks at the material has the best estimate of the age of the material.

MR. COFFEY: I move to strike that. None of that was asked about pathologists in that last question.

THE COURT: Overruled.

Q. You didn't mention pathologist in your answer; did you?

A. No. You asked me a question about pathologists.

Q. Doctor, in that question and answer, you never mentioned the word pathologist under oath; did you?

A. I have no idea what you are talking about. You asked me a question and I answered it.

Q. Yes. And when you were asked that question in Chicago, you said --

A. Right, in Chicago. I thought you meant this interchange. In Chicago, they asked me if I, as a pediatrician, would be more -- would be better at aging a subdural than a radiologist, and I said a radiologist would

have more expertise in dating a subdural than a pediatrician.

Q. The baby died in that case; didn't he?

A. Yes, eventually, yes.

Q. Now, I want to ask you now -- I'm going to show you a part of the record from -- I would like you to look at this, dated 9/21/2008. And that's a report signed by a Dr. Hoover; correct?

A. Yes.

Q. He's a neuroradiologist; correct?

A. Yes.

THE COURT: Mr. Coffey, is this document in evidence?

MR. COFFEY: Yes. It's part of the medical records. If you want me to mark it separately, I will do that.

THE COURT: What's it a part of?

MR. COFFEY: Part of the Albany Medical Center records.

THE COURT: Defendant's D that you just moved in?

MR. COFFEY: Right.

THE COURT: That's fine.

Q. Have you ever seen that report before?

A. Yes.

Q. He's more qualified than you, isn't he, in dating?

A. To date radiological studies, yes.

Q. You must have talked to Dr. Hoover?

A. I did not.

Q. Well, if I wanted to find out with regard to whether there was a subdural hematoma, I would want to know from the neuroradiologist; wouldn't I?

A. I read his report.

Q. I would want to know from the neuroradiologist personally; wouldn't I?

A. If it's a patient that I'm actually seeing, yes. I would sit down and go over the films with the neuroradiologist; but if it's a patient I'm reviewing records of, that, historically, I don't have access to all the doctors that have taken care of this child.

Q. Doctor, you could have asked the District Attorney's Office for Dr. Hoover's phone number, who is local, and asked to speak to him; correct?

A. I read his report.

Q. You could have.

MR. COFFEY: Judge, I move to strike that answer. I asked if she could have, not what she did.

THE COURT: Overruled.

Q. You could have asked the District Attorney to speak to him; correct?

THE WITNESS: What was overruled? I'm sorry. I

don't understand.

THE COURT: You can answer this next question.

THE WITNESS: I can't?

THE COURT: You can.

THE WITNESS: I can.

A. I could have, yes. I could have called up and asked to speak to anybody I want. I don't know if they would have spoken to me.

Q. And Dr. Hoover would be the person who would be in the best position, would you agree with me, as to what is on those -- that CAT scan. Would you agree or disagree with that?

A. What's on the CAT scan? Yes. I agree that he would be in the best position.

Q. And Doctor, Dr. Hoover never indicated at all that there was a subdural hematoma; did he?

A. He said there probably was.

Q. Really? Would you read that to the jury?

A. It says, "Large bilateral extraaxial fluid collections, probably subdural on the right, and possibly the same on the left. MRI is recommended to distinguish between subdural collections and enlargement of the subarachnoid spaces."

Q. He didn't call it a subdural hematoma, though; did he?

A. No. He didn't use the term hematoma.

Q. So, now we have got two critical people, which you would agree, Dr. Edge and Dr. Hoover, who are involved in this baby's care and treatment when he comes to the hospital, and what their opinion is or not, you have no idea; correct?

A. I just read the record. So, that's all I know.

Q. Now, when -- you indicated, I think in your direct testimony, that in your opinion, there was acute subdural hematoma; correct?

A. Yes.

Q. Is that what your opinion is?

A. Well, that was what the treating physician said. That's what the neurosurgeon said, and that's what the autopsy report showed.

Q. What treating physician said that?

A. The intensive care doctors put that in their notes.

Q. Who was that?

A. It was one -- it was in the standard notes. Several times, they said acute and chronic or subdurals of different ages, and I think, actually, the neurosurgery notes said acute and chronic.

Q. What did the intensivist base his opinion on, if you know?

A. I assume --

Q. I'm not asking you to assume. Do you know?

A. The only way they would know would be to look at

imaging studies.

Q. Well, intensivists can't read a CAT scan as well as a radiologist; can he?

A. No.

Q. So, let's -- so, on assumption, you are assuming that he read this; correct? You are assuming that; correct?

A. Well, somehow, he got information on the case that there was subdurals of different ages, as well as the neurosurgeon, who reads CAT scans all the time.

Q. Well, that may be. But in terms of the intensivist, where he got it or whatever, you don't know; correct?

A. I assume he got it from the radiologist. I don't know directly.

Q. Now, let's not talk about assumptions for the moment. Let's talk about what's in the record. When [redacted] -- withdraw that. When you indicate that that baby had an acute subdural, you have not read the CAT scan; have you?

A. I have not.

Q. You are not qualified to read CAT scans; are you?

A. I do it all the time with radiologists. I wouldn't do it on my own.

Q. Okay. And the slides in this case, you have not read them, either; correct?

A. I did not.

Q. So, therefore, your testimony today is based upon

opinions and assumptions made by others; correct?

A. It was based on the report of the autopsy and review of the medical records.

Q. Others?

A. Yes.

Q. You have no hands-on experience in this case; correct?

A. I was not in Albany at the time of this case.

Q. I guess the answer to that is yes?

A. September of 2008, I was not involved in this case.

Q. So, the answer is you have no hands-on experience; correct?

A. On this case, yes.

Q. Well, I don't care -- do you think we are talking about some other case here?

A. In this case, I have had no hands-on experience.

Q. Now, [redacted], you have testified -- and, in fact, it's been your opinion for 30 years, if not more, isn't it, that if you have a severe head injury, a baby is going to show immediate signs of distress consistent with that severe head injury; correct?

A. Um, in the literature --

Q. Is that correct or is that incorrect?

A. That's not quite the full story. In the literature --

MR. COFFEY: Move to strike.

A. -- the onset of symptoms.

MR. COFFEY: I move to strike anything further, Judge.

MS. BOOK: Objection, Your Honor.

MR. COFFEY: I'm not asking for an explanation.

THE COURT: Let the witness answer the question. You can follow up on redirect. I will let you ask a new question, Mr. Coffey.

A. Not necessarily. It depends on the nature of the injury and the nature of the damage.

Q. A severe head injury such as this baby suffered, it has been your opinion consistent in the past that a baby would experience visible signs consistent with having a severe head injury; correct?

A. Um, yes. When babies get severe head injuries, they don't act normal.

Q. Okay. Now, having said that, now I want to ask you some questions, if I might. We had -- I'm going to withdraw that. This acute subdural which you claim -- which somebody else has told you about, how old is that?

A. I didn't read that anybody gave it a specific age. Most people in the field, in radiology and pathology, or in radiology would say acute is one to three days.

Q. One to three days?

A. Or from zero to three days.

Q. All right. Now, [redacted] was brought into Samaritan -- and you can assume this for the moment, the days. He was brought in on a Sunday morning. Okay?

A. Yes.

Q. Is that consistent with what your recollection is?

A. Yes.

Q. So, he gets brought into Samaritan Hospital. And from Samaritan Hospital, he's then transported to Albany Medical Center; correct?

A. That's right.

Q. And at Samaritan Hospital, he at that time is, unfortunately, on the road to his death; isn't he?

A. Yes.

Q. He has -- he's hypotensive; right?

A. Yes.

Q. Meaning low blood pressure?

A. Yes.

Q. His white blood count is perilously low; right?

A. That's right.

Q. He is nonresponsive; right?

A. When he arrived at the medical center, yes.

Q. Well, was he responsive at Samaritan, if you know?

A. Well, on the EMT call, they said that he was responsive to stimulation; but by the time he got to Samaritan,

they didn't have that finding.

Q. So, he's got a low blood count, low platelets, hypotensive. If he's responsive, he's barely responsive at Samaritan Hospital. They know at that time they've got a problem taking care of this little baby. So, they immediately ship him over to Albany Med; correct?

A. Yes.

Q. I say "immediately," maybe within a half-hour or an hour?

A. Within a short time, yes.

Q. And the doctor who sees him, the emergency room physician, she diagnoses, in fact, has testified that, in her opinion, the diagnosis was and is sepsis. Are you aware of that?

A. I didn't know what her testimony was.

Q. Do you care?

A. I know that on her differential diagnosis, she had sepsis and head injury, but she didn't have any imaging studies to make a diagnosis.

Q. I'm sorry. I didn't ask you that. I asked if her opinion was sepsis. I didn't ask about a head injury.

A. She had that on the list of differential diagnosis.

Q. She testified here in court a couple days ago that, in her opinion, that baby had sepsis. Are you aware of that?

A. I didn't hear that testimony.

Q. In any event, she comes to the conclusion, board certified, that [redacted] had sepsis. Now, you are not an expert in infectious diseases; are you?

A. No.

Q. And in fact, there are experts on -- pediatric infectious disease experts; aren't there?

A. Yes.

Q. And these are experts in the field in various hospitals around the country, such as small hospitals that may be manned by a school at Harvard?

A. I'm sorry. I didn't understand.

Q. You have heard of Harvard; correct?

A. Harvard, yes.

Q. One of the leading medical schools in the world; right?

A. Yes.

Q. And there are infectious disease experts associated, if you know, with institutions such as Harvard or Stanford or Texas, whatever; correct?

A. Yes.

Q. And doctors oftentimes will defer or go to those kinds of doctors and ask a doctor, "You got to tell me some information with regard to this infection," right?

A. Right.

Q. It doesn't make a doctor bad or stupid or

incompetent. It simply means one doctor is willing to defer to the expertise of another; correct?

A. That's right.

Q. Have you ever heard the name of Dr. Jerome Klein?

A. Yes.

Q. And Jerome Klein is one of the leading authorities in the country on pediatric infectious diseases; isn't he?

A. He's a distinguished academician, yes.

Q. Is that a criticism?

A. No.

Q. He's a clinician, as well; isn't he?

A. I'm sorry?

Q. He's a clinician, as well?

A. He's done a lot of research. He's a very highly respected doctor.

Q. Okay. And when you met with the District Attorney's Office, did they talk to you about Dr. Klein?

A. They said that Dr. Klein had said that the child had pneumococcal sepsis.

Q. Did they tell you that they had -- Dr. Klein's opinion was that it was severe sepsis when he went into that hospital?

A. I think I read that, yes.

Q. You --

A. I read the testimony from a previous event.

Q. Do you disagree with that?
A. No. He was critically ill.
Q. Do you disagree that he had severe sepsis?
A. No. He had sepsis. He had severe sepsis.
Q. Fair enough. So, now the baby develops severe sepsis. And with sepsis, you mentioned -- you were kind enough to tell us what happens. This bacteria, it's actually in your throat; correct?
A. When you are septic, it's in your bloodstream.
Q. Well, pneumococcal pneumoniae -- or staphylococcal pneumoniae, that bacteria, do we all have that?
A. A lot of people carry it.
Q. A lot of kids have it?
A. In their throats, yes.
Q. And the process that occurs is it gets in the throat. It can migrate into the lungs; right?
A. Yes.
Q. And from the lungs, it can go into the bloodstream; correct?
A. Yes.
Q. And that's bacteremia; correct?
A. Yes.
Q. We don't want bacteremia in the blood; do we?
A. No.
Q. That's bad; right? And if bacteremia begins to

colonize the blood, it can begin to spread throughout the bloodstream and, of course, the blood is being pumped by the heart. The blood is going all over, to the organs, the brain. And if it becomes infected, septic, it can hit every organ; right?

A. Yes.

Q. And if that happens, the sepsis can overwhelm a baby's ability to fight off the infection; correct?

A. Right.

Q. And kill him; right?

A. It can, yes.

Q. Now, you have a situation where the baby comes in on Sunday, and I think you told us that the acute subdural would be from day zero to day three; correct?

A. Based on the imaging studies, yes.

Q. Based on what you have been told, anyway?

A. Right.

Q. Just so we know, in medicine, I'm going to take day zero as Friday, or day one if you want. Saturday is day two, and Sunday is day three. Would you accept that, or would you go to day zero as Thursday?

A. Just based on the radiology, again, I would say that's reasonable.

Q. Friday, Saturday, Sunday; correct?

A. Yes.

Q. Now, let's stay away from -- I will withdraw that. If the baby had suffered a severe -- to cause this kind of damage, we are talking about a severe head injury; aren't we?

A. Yes.

Q. And if he suffered a severe head injury, you are talking about taking a baby -- a four-month-old baby, two months premature. You know that; right?

A. Yes.

Q. Or six weeks premature?

A. Seven weeks.

Q. Seven weeks. Okay. Six to eight, seven. Okay. And you are talking about applying a lot of force to that baby's head; aren't you?

A. Yes.

Q. Okay. And when you apply that kind of force to that baby's head, whether you throw it or drop it or drop kick him - and I'm not being facetious - you are applying tremendous forces to that little baby's -- I'm not talking about any part of his body. To his head; correct?

A. Depending on the nature of the injury, yes.

Q. We are talking about this injury. Tremendous force; correct?

A. Right.

Q. Dr. Waldman called it a serious application of force. Okay? You would accept that; wouldn't you?

A. Yes.

Q. That baby -- you would never recommend that, obviously; right?

A. No.

Q. And the mother, who is with that baby, who has not been criticized and will not be criticized and is not being criticized, that mom would be able to pick up, something has happened to my son; wouldn't she?

A. Well, it depends, because sometimes kids can take a hit, get symptomatic and then start to recover until they take another hit. So, if you see them in that recovery period, it may be very difficult to diagnose.

Q. I thought you told us you would have visible signs immediately?

A. You do, but kids can get better and bounce back.

Q. How much longer?

A. It depends on the case. I have done multiple cases where people say -- they tell us they abused the kid multiple times, and each time the kid gets acutely -- you know, stops breathing or has trouble breathing or gets very sleepy and then, over time, they go back to normal.

Q. Fair enough.

A. And then after multiple events, they finally get pushed over the edge.

Q. I'm talking about this weekend. That's all I'm

talking about, Doctor. Stay with me here. This baby has a serious application of force. I don't care what happened in August. I don't care what happened in June. When that happens -- and mom is with him the entire weekend. Are you aware of that, except for --

A. Not the entire weekend. She said there were times when she was in the home when she wasn't supervising.

Q. Who told you that?

A. She said that in her statement. She said that in the hospital records.

Q. Well, mom testified that she was out maybe for about an hour or so?

A. She wasn't there continually, is what she said in the hospital records.

Q. Well, her daughter was there. Okay? She's testified in this case. Are you aware of that?

A. No.

Q. So, now you've got two responsible -- well, at the time, this child was nine. She's now 15, or 14, I think. So, now you've got two people there, and this force that's being applied, are you aware of the fact that mom never sees the loss of consciousness in the entire weekend? Are you aware of that?

A. On Sunday morning, she did.

Q. Day three?

A. Yes. That's right.

Q. And that's at eight o'clock when she goes in to wake the baby up; right?

A. Correct.

Q. Are you aware of the fact that from Friday, day one, to day three, the baby is feeding well. Are you aware of that?

A. I was told that. Well, she was feeding Pedialyte®, which is not formula. She wasn't feeding formula.

Q. Is it your understanding he didn't have formula?

A. Say again?

Q. Your understanding is he did not get formula this weekend?

A. Well, certainly, the last few feedings, they were feeding him Pedialyte® because he had difficulty with diarrhea.

Q. Do you know if he had formula?

A. I just remember her saying that at 4:00 a.m., somebody gave him Pedialyte®.

Q. What kind of a history were you getting, if that's all you know?

MS. BOOK: Objection.

Q. I will withdraw that. Do you know -- Doctor, as you sit here today testifying in a case involving a man who is accused of murdering his child, do you know what the mother has testified to the baby's condition Friday night, day one; do you know?

A. All I know is what I have read in the record.

Q. Do you know, as you sit here today - tell this jury - what the mother testified to regarding his condition Friday night?

A. No. I wasn't allowed in the courtroom. I wasn't here.

Q. Did you ever ask anybody?

A. I just read what was in the records.

Q. Do you know what the mother testified to the baby's condition all during the day Saturday? Do you know?

A. In the medical records, she said that he had a period of irritability on Saturday night.

Q. This is after 11:00. Is that correct?

A. I don't remember the timing.

Q. You don't even know the history, then; do you, Doctor?

A. I have read the record. I haven't memorized it.

Q. Did you think I was going to ask you questions today about the history that weekend?

A. I didn't know what you were going to ask me.

Q. Really?

A. Really.

Q. Now, if I were to tell you that Mrs. Hicks said that that baby was happy and healthy the entire weekend, the entire weekend up to Sunday morning, had some problems at night, a little bit of -- 100.4 fever. But that's not a big fever; is

it?

A. No. That's actually a normal temperature for a child this age.

Q. Babies go to 104?

A. That's within the normal range. You don't start calling it a fever at that range, especially if it's a rectal temperature.

Q. From her testimony, except for maybe one hour in which her daughter was with Matthew, this baby, the entire weekend, except for maybe the little bit of problem with the temperature, the entire weekend, she said she saw no physical signs of any distress of that child. Are you aware of that?

MS. BOOK: I'm going to object to that, Your Honor. I think it's a mischaracterization of Wilhemina Hicks' testimony.

THE COURT: Mr. Coffey?

MR. COFFEY: I don't believe it's a mischaracterization at all. I think that's exactly what she said.

MS. BOOK: She called her mother to come look at the child. He had a fever on Friday night. She went and got Pedialyte®. She gave a history of diarrhea. She knew he didn't feel right. She woke him up and she made a determination if he wasn't better by Sunday morning, she was going to take him to the hospital. So, to sit here

and say that she was with him all weekend and had no problems and put that out to the doctor as facts in this case is just wholly inappropriate and misleading.

THE COURT: The record speaks for itself. I understand both parties' position. I'm going to overrule the objection. The People can follow up in that regard if they see fit.

Q. Let me ask you this, Doctor. I'm going to take you through exactly what Ms. Book -- you just heard what she said; right?

A. Yes.

Q. Well, what she hasn't told you is this: That during the day Friday, up to the time on Friday night, [redacted] was okay. He was happy. Saturday, the fever from the night before broke. All right? He had some diarrhea. She gave him some Pedialyte®. He was okay Saturday. Saturday night, he had another fever, a little cranky, but she thought, I will see what happens in the morning, wasn't taking him to the hospital. No problems during the day Saturday. No problems during the day Friday. Are you with me so far?

A. Yes.

Q. Saturday morning, she fed him -- Sunday morning, I apologize.

A. Yes.

Q. Sunday morning at eight o'clock, the baby was

nonresponsive. I want you to assume those facts. There's nothing in that that is in any way consistent with a baby suffering acute injury; is there?

A. Well, I mean, she did say to the hospital social worker that --

Q. Doctor, please take the facts that I have given you. I'm not asking about a social worker.

A. The case as I read it was different than that.

Q. Let me take what she told the jury, because they are the ones that are going to decide this. So, why don't you take the facts -- and you testified many times, Doctor. So, I'm asking you to assume the facts that I have just told you. And assuming those facts, there is nothing that's consistent with a head trauma; is there?

MS. BOOK: Your Honor, I'm going to object and ask that Dr. Jenny be allowed to answer fully. It's been asked about, it's now questioned on. Dr. Jenny should be allowed to fully explain herself.

THE COURT: Mr. Coffey can present a hypothetical, and he's allowed to do that. You can follow up on redirect.

MS. BOOK: I understand he's allowed to present a hypothetical, but he's presenting the facts of this case as if --

THE COURT: He presented what you just

represented the testimony is, if I'm not mistaken. So, I don't think there's anything inappropriate about that. As I said, if you want to follow up on redirect, you are certainly free to do so, but I'm going to allow the question.

Q. There's nothing in this case at all from the mother that this child suffered any abuse; correct?

A. Well, I mean, he was irritable, and that's a sign of a head injury. That can be the sign of a head injury.

Q. When he had -- at 11:00 at night, I think she said, it's my recollection, slightly cranky, but he was not irritable during the day Saturday. He was not irritable during the day Friday.

A. He was irritable -- her description in the hospital social work note said he was irritable Saturday night.

Q. Let's take the testimony as I have given you, Doctor, and I'm going to keep bringing it back to what I'm asking you in this case. All right? I don't care what she told -- I care what she told the jury. On the facts that I have supplied to you that she's testified here today, having met multiple times with the District Attorney, that she does not give anything that's descriptive and associated with head trauma. Isn't that true?

A. Irritability can be -- and I don't know the extent of the irritability that the baby showed, but that can be a sign

of head trauma.

Q. Even if it's for five seconds? Is that what you are telling us?

A. I would doubt it would be five seconds.

Q. You don't know?

A. I don't know how long the child was irritable.

Q. So, you are coming before a jury and you are now speculation on irritability, how long it took; right?

A. I'm saying, in general, irritability is a sign of head trauma.

Q. In general. But you have to know how much time and so forth?

A. It wasn't reflected in the record.

Q. Now, this child didn't have any sleeplessness, wasn't unconscious or didn't sleep -- wasn't unconscious or sleepy, didn't have any marks on his body. Are you aware of that?

A. Yes.

Q. And I know you said that it's not always the case that a child who has severe head injury that he would show marks. But tell me: If I slam a little baby on whatever I'm slamming him on, chances are, at some point in time, that baby is going to exhibit some marks on his face or head; isn't he?

A. It depends. It really depends.

Q. Well, isn't it likely?

A. Because their skulls are soft, and their skulls do

bend when they have impact; and it's very common to not see any external trauma and, at autopsy, to find bruising or bleeding underneath the scalp.

Q. But we are talking about repeated acts of trauma. Is that what you are telling us?

A. I would think, in any one event, you may or may not see external lesions.

Q. But my question to you is on repeat -- you said there were repeated events of trauma. Didn't you say that?

A. Yes.

Q. If I had repeated events of trauma where I'm slamming the baby down, not just his skull, but his neck, his collarbone, his stomach, his legs, the more you do it, the better chance you are going to start having marks on that baby; right?

A. It depends on what you do. It depends upon the nature of the forces that are applied to the body and how frequently, how often and the severity of the forces.

Q. You told us that he had multiple acts of severe trauma. Didn't you tell us that?

A. Yes, because he had old and new subdural hematomas.

Q. I understand that. My question, then, to you, Doctor, is specific, and you can tell me no, if you'd like. Wouldn't you agree that, if you actually did have multiple acts of trauma, that at some point in time, that baby, some part of

his body, would exhibit signs of having been hit or hurt? Wouldn't you agree with me?

A. Not necessarily.

Q. Now, the -- let's talk about September the 13th. September the 13th, this baby had a rash on him. He had a rash; didn't he?

A. Yes.

Q. Now, a rash is not a black and blue; right?

A. No.

Q. That was an open portal; right? In other words, the rash had some skin opening; right?

A. Well, they described it as a blister.

Q. Well, blister. If it broke or whatever, would have an open wound; correct?

A. Well, it may be covered with skin. I don't know. They didn't specifically say that.

Q. All right. Now, the baby appeared to be -- okay. Well, maybe he didn't. How was that baby? How was [redacted]?

A. They said he was normal.

Q. Let me go now to the hospital, when you get to Albany Med.

A. To Albany?

Q. Albany Med on September the 21st, I believe, Sunday. When he got to the hospital, at that time, he had -- as it turned out, he had brain swelling; correct?

A. Yes.

Q. Consistent with sepsis; correct?

A. Consistent with many things, consistent with an insult to his body.

Q. I'm sorry, Doctor. I didn't ask about many things. Please, Doctor. Stay with the question I'm asking you. It's consistent with sepsis; correct?

A. It can be.

Q. Can be. Hypotension can be consistent with sepsis; correct?

A. Yes.

Q. Meningitis, did he have meningitis?

A. Um, according to the autopsy report, they didn't talk about meningitis on the autopsy. So, I don't know. Nobody did a spinal tap.

Q. Okay. He had -- his blood count crashed, where he's down to, like, one; wasn't it?

A. Yes.

Q. Consistent with sepsis; correct?

A. Yes.

Q. He had platelets. His platelets were not clotting. Consistent with sepsis; correct?

A. He had a low, but not dangerously low, platelet count.

Q. Well, it actually got much worse when he was in the

Medical Center; correct?

A. It did, yes.

Q. And the DIC -- which is disseminated, meaning it goes all through your body; correct?

A. Yes.

Q. Intravascular means it gets into the vessels of your body; correct?

A. Yes.

Q. Into everything; correct?

A. Well, on autopsy, he had normal liver, kidneys and spleen.

Q. Well, it was in his heart and his testes?

A. I'm sorry?

Q. It was in his heart and testes?

A. Yes.

Q. When he came into the hospital -- when you have a DIC, you are, in effect, bleeding out; aren't you?

A. Say it again.

Q. When you have a DIC, you are, in effect, bleeding out. In other words, you have uncontrollable bleeding; correct?

A. Yeah, if it's very severe.

Q. Well, this baby had severe DIC; didn't he?

A. He didn't have uncontrollable bleeding on his skin or at the IV marks. He was functionally not bleeding externally.

Q. He had classic signs of DIC; didn't he?

A. Well, he had hematologic signs. He has blood signs of DIC. He had no evidence of bleeding in his kidneys, no evidence of bleeding in his gut, no evidence of bleeding in other organs where we usually see it.

Q. Well, he had a lot of blood in his brain; didn't he?

A. He did have blood in his brain.

Q. Now, DIC, if not controlled, will continue to bleed; correct?

A. Yes.

Q. They were trying to stop it, but they were unsuccessful; weren't they?

A. Yes. The DIC -- actually, yes. He was dead at that point.

Q. So, when he comes in Samaritan in the morning and goes over to Albany Med in the afternoon, that DIC is continuing to work its evil ways; isn't it? It's continuing?

A. Until he was treated, yes. Then he got better.

Q. Okay. Now, DIC is -- can be consistent with sepsis. I know it can be consistent with a lot of other things. Consistent with sepsis; correct?

A. Yes.

Q. So, he's got low blood count, heart failure. He had heart failure. Didn't he have a heart attack?

A. When he first came in, he had a very low heart rate.

I don't think that there is was any evidence that he had acute heart failure. He was bradycardic, meaning slow heart.

Q. He was actually tachycardic and bradycardic?

A. Well, he was first bradycardic, and then they gave him pressors, which makes your heart rate go faster.

Q. So, this baby, every system in his body was shutting down; wasn't it?

A. No. His kidneys were normal. His liver was okay.

Q. Okay, except for those. He had some multiple organ failure here; didn't he?

A. No, I don't think so. I wouldn't call this multiple organ failure. You can't have normal kidneys and have multiple organ failure.

Q. Well, in any event, he had a bleed consistent with sepsis and that was a DIC; correct?

A. He had a bleed -- are you talking about his head?

Q. I'm talking about the bleed he had.

A. In his head, you mean?

Q. Correct.

A. Well, you know, it depends. I have seen a lot of kids with DIC from other things, and the head is not usually where they bleed. They usually bleed first in their kidneys and their livers and their guts.

Q. That's a matter that an infectious disease expert would be more qualified?

A. I'm just telling you what I have observed in many cases.

Q. Stay with my question, Doctor. Wouldn't you agree with me that an infectious disease, pediatric infectious disease expert would be more qualified than you to give an opinion in that regard? Would you agree or disagree?

A. I would disagree, because the people that deal with this most are the intensivists and the trauma doctors, not ID doctors.

Q. But the intensivist is Dr. Edge?

A. That's right.

Q. Do you know if he's coming in to testify?

A. I don't know.

Q. He would be the person to talk to, wouldn't he, according to you?

A. I think --

Q. That's what you just told us; right?

A. Lots of us deal with DIC. It's a common problem that lots of pediatricians who take care of hospitalized critically ill patients deal with. So, you could say a hematologist would be better off doing it or the traumatologist. Most of -- trauma is the most recent cause of DIC that we see.

Q. Are you done?

A. I'm finished.

Q. I thought you just told us that the intensivist would

be the person who knows this?

A. Well, the people who deal with these kids are in intensive care. So, most of the people who see the trauma are the ICU docs; and those of us who work in Intensive Care Unit deal with it all the time.

Q. Isn't it true the retinal hemorrhages that you talked about -- I will withdraw that. Retinal hemorrhages are caused by pressure; right?

A. Increased intracranial pressure, you get a very specific type of retinal hemorrhage, which isn't the type this baby had.

Q. Well, isn't it true that retinal hemorrhages can be caused by things that have nothing to do with trauma?

A. Lots of things cause retinal hemorrhages. It's a question of where they are located and what the patterns are.

Q. And if you were to be told that an infectious disease expert were to say that this baby's problems were caused by sepsis and not trauma, you would disagree with him; wouldn't you?

A. You can get those extensive retinal hemorrhages in septic babies and you can get them with trauma, and you can get them in bleeding disorders, severe; like kids that have hemophilia or severe bleeding disorders or kids who have Vitamin K deficiency. There's many different things that can cause it. There's four or five things that can cause severe

retinal hemorrhages. There's hundreds that can cause little tiny retinal hemorrhages behind the eye.

THE COURT: Ladies and gentlemen of the jury, we are going to take a break at this point in time. During this break, please don't discuss the case. Don't read or listen to any media accounts. Don't form any judgments or opinions. Don't request or accept any payments in return for supplying any information. If anyone attempts to improperly influence you, please report that directly to me. We will break for 15 minutes at this time. Okay.

(Jury excused.)

THE COURT: Doctor, as I told you before, please don't discuss your testimony with anyone, including the attorneys. See you back here in 15 minutes.

(Brief recess taken.)

THE COURT: Please be seated.

(Samaritan Hospital Records marked Defendant's Exhibit E for identification.)

THE COURT: We are outside the presence of the jury. I will place on the record that as I was leaving the bench and walking back to chambers, one of the members of the jury had inquired of me if she could ask me a question. I told her that I could not speak with her; that if, when I brought them back into court, if she had a question to ask, I will allow her to do so in the presence

of the parties. It would, therefore, be my intention at this time, when the jury comes back into court, to inquire whether this particular juror had a question. Is that okay with the People?

MS. BOOK: Yes, Judge. Thank you.

THE COURT: Is that okay with the defense?

MR. COFFEY: Yes, Judge.

COURT OFFICER: All rise. Jury entering.

THE COURT: Please be seated. Before we resume with the trial testimony, I would note that one of the jurors had inquired of me when we were on a break whether she could ask a question. I advised that juror that I couldn't speak to the jury outside the presence of the parties. Ma'am, is there a question from either you and/or the jury at this time?

TRIAL JUROR: I won't ask my question at this time. I will choose not to ask it.

THE COURT: Okay. Are you sure? Because if you have a question that you feel pertains to this case or pertains to your role as a juror, I would be happy to entertain that question. I'm not telling you you have to ask it, but I just want to acknowledge that you attempted to ask me a question in the back. I told you I couldn't speak to you outside the presence of the parties, and I want to afford you the opportunity at this time to ask a

question if you feel it's appropriate or you need to; and if you want to ask a question, you may do so. If you are asking to speak to me privately, you may do that, as well. By privately, I mean on the record but not in front of everyone else in the courtroom. Or if you believe that the question is unnecessary, you may forego asking it. Do you understand that?

TRIAL JUROR: I do, Your Honor. Thank you. I will forego asking it at this time.

THE COURT: Thank you. People satisfied and prepared to proceed?

MS. BOOK: Yes.

THE COURT: Defense satisfied and prepared to proceed?

MR. COFFEY: I have no questions. I'm good. Thanks.

THE COURT: Okay. The sworn witness remains Carole Jenny. Doctor, I will remind you you are still under oath. Mr. Coffey, you may proceed when you are ready.

BY MR. COFFEY: (Continuing)

Q. You know, Doctor, does it strike you that there's a lot of coincidental things that occurred in this case?

A. I'm sorry?

Q. Let me see if I can follow here. You claim that

there was an acute event from day zero -- or from Friday to Sunday which caused trauma; correct?

A. Yes.

Q. Yet, ironically, at the very same time this occurs, this baby develops a massive sepsis, shock; right?

A. That's right.

Q. Same weekend; right?

A. Yes.

Q. And you talked about aspiration before; correct?

A. Yes.

Q. There's no aspirations anywhere in this record; is there?

A. Well, you can't tell that, because lots of kids that get head injuries have what we call silent aspirations. They don't cough. They don't choke. Stuff goes down their throats.

Q. I'm sorry, Doctor. I didn't ask about other kids. I asked about the record. There's nothing in this record that indicates this child aspirated; is there?

A. There's nothing that indicates it and you can't rule it out.

Q. We can't rule out what -- well, let's see. Actually, when you can't rule out things, you now think, well, maybe the baby aspirated, right, maybe?

A. It's possible.

Q. Possible. And he has sepsis, which is a -- he has

objective signs of sepsis; doesn't he?

A. Yes.

Q. We don't have to go to anybody and wonder about that. He's got sepsis. It's septic shock. And by the way, he was bleeding in his eyes; wasn't he?

A. Yes.

Q. So, we know he has sepsis. And sepsis, when that gets in your bloodstream, that goes right through it; doesn't it?

A. It depends. It depends on the nature of the host or the person's immune system. It depends on how toxic that particular species of bacteria is.

Q. Well, the staphylococcal pneumonia here goes right through your bloodstream once it gets in there; doesn't it?

A. Well, I don't know how long it took.

Q. So, it goes -- well, are you aware of the fact that Dr. Klein opines that on Friday, this sepsis gets in this boy's bloodstream and hits it; and by Sunday, it's killed him? Are you aware that's his opinion?

A. No.

Q. Wouldn't you want to know the opinion of someone who may disagree with you, or you don't care?

A. I guess it important for the jury, certainly. It's important to the judge and jury. I can't have access to people I don't have access to.

Q. You can read their testimony.
A. I did from the last one.
Q. Yes.
A. I don't remember the Friday to Sunday testimony.
Q. Do you have a filtered memory? Do you remember things you want to remember?
A. I read a stack of stuff that high. I didn't remember every single word.
Q. Now, so, if he developed sepsis that's unrelated to the trauma, you don't know whether that's true or not; correct?
A. If it's unrelated to trauma?
Q. Right.
A. I don't know that.
Q. Now, when you talk about trauma, it can be accidental or intentional; correct?
A. Yes.
Q. And I want to ask you something about this, about the hypothetical you were given before. Remember the sequence of the questions you were asked about the baby bouncing on the bed?
A. Yes.
Q. Okay. Well, let's assume this jury bar is a bed. Okay? (Indicating) And I'm doing something here, bouncing a little four-month-old; right? Okay?
A. Okay.

Q. Now, let's go to, say, 17 inches, okay, which is -- tell me where you think 17 inches is.

A. Well, a little more than a foot, a foot and a half.

Q. Okay. So, I'm bouncing a little baby on a bed; right?

A. Yes.

Q. And the baby bounces and falls off the bed. Is that severe trauma to you?

A. It depends on the distance of the baby.

Q. No. I'm talking -- Doctor, stay with my example, please.

A. From that distance, if the head were supported, it wouldn't cause any problems.

Q. So, if I'm bouncing the baby on the bed and the baby falls off, that wouldn't cause severe trauma; would it?

A. Not necessarily.

Q. And whether the baby is at 17 inches or 18 inches -- oh, do you know how far the bed that we are talking about, the top of the bed was from the floor in this case?

A. Seventeen inches.

Q. Okay. So, we don't have to speculate. We know we are talking about 17 inches; right?

A. Well, that's how high the surface was. I don't know how high the person was that was throwing the baby onto the bed.

Q. I'm sorry. Would you repeat that answer?

A. I don't know how high the person was who was bouncing the kid off the bed.

Q. Well, actually, you didn't say bouncing. You just used the word throwing; didn't you?

A. Yes.

Q. You don't have any evidence that he was throwing that baby; do you?

A. Um --

Q. Do you?

A. In this case, no; in this particular version of the case, no.

Q. Why would you use that word throwing? Didn't you think that we would listen to that word, and tell this jury that you are using the word throwing, when you know very well that throwing means something? Why did you use that word?

A. Well, my understanding was he was standing and was not letting the baby -- was not pushing, holding the baby right over the bed and dropping him; that, in fact, he dropped him from some distance.

Q. Why did you use the word throwing?

A. It just seemed relevant.

MR. COFFEY: Well, I guess we are going to find out in a couple of days. That's all I have.

THE COURT: Ms. Book, any redirect?

MR. COFFEY: May we approach?

(Sidebar discussion held on the record as follows:)

MR. COFFEY: Judge, we would move for a mistrial based upon Dr. Jenny's statement, her opinion based upon this version of facts.

THE COURT: Ms. Book?

MS. BOOK: Your Honor, I don't think this rises to the level of a mistrial. I, obviously, told Dr. Jenny what she could and could not say at this trial. I told her not to mention -- I don't want to get into it, but I told her not to mention anything from before, and I don't think that she meant it as a prejudicial statement. I think it just came out that way, and it's harder for doctors to live in the legal --

MS. EGAN: Judge, can I add something? Mr. Coffey was also discussing several different hypotheticals, one being -- he actually said slamming the child on the floor and then bouncing the baby on the bed at 17 inches; and she, in fact, corrected her statement and said bouncing the child. So, I think that there's -- I don't think it rises to the level of a mistrial because we have been discussing -- Mr. Coffey was discussing certain hypothetical versions of facts with the witness.

MS. BOOK: Different versions of events.

THE COURT: The Court will reserve on the Defendant's application. We will continue and then I will issue a decision at the appropriate time.

(Proceedings continue in open court as follows:)

MS. BOOK: May I have one moment, Your Honor?

THE COURT: Yes, you may.

REDIRECT EXAMINATION

BY MS. BOOK:

Q. Dr. Jenny, did you review the records in this case?

A. Yes.

Q. Did you speak to every doctor involved and all of the witnesses in this case?

A. No.

Q. Why not?

A. First, it would take an enormous amount of time. It would cost you guys a lot of money. And second, I rely on the medical record as recorded. That's what medical records are for.

Q. If you felt that you did not have a full picture of what happened from the medical records, would you be able to give an opinion here today?

A. I feel very comfortable with the opinion I'm giving. Yes. The question was, if I didn't have a full understanding of the record, would I give an opinion?

Q. Yes.

A. I would not if I did not have a full understanding of the record.

Q. Okay. So, whether it was Dr. Edge or Dr. Hoover that performed a particular test or whether it happened at 8:00 in the morning or 10:00 in the morning, does all of that -- does any of that change your opinion today?

A. It does not.

Q. If a person is suffering from DIC, would you expect, in your medical experience, for them to have a normal liver and spleen?

A. Liver and kidneys, you mean?

Q. Liver and kidneys?

A. That's unusual. Those are usually organs that take a hit.

Q. Why is that?

A. Because they have very high blood flow through them.

Q. So, can you explain to us why it is that they would take a hit?

A. Well, because they get a lot of blood going through, so they get a lot of exposure to the bacteria.

Q. Would you expect to see clotting in those organs?

A. Yes.

Q. Now, Mr. Coffey asked you the difference between subjective and objective signs here. Was there objective signs of head trauma to [redacted]?

A. Yes.

Q. And what were those objective signs?

A. The subdural hemorrhages that were healing and brand-new.

Q. Anything else?

A. Well, I mean, there's other things that we see commonly, like we see DIC in infant head trauma. We see hypotension. We see low body temperature. We see cardiovascular or cardiorespiratory arrests. Those are common findings.

Q. And did [redacted] present with those findings?

A. Yes.

Q. Now, as a consultant in a case, as you are in this case, are you limited to the records that you have?

A. Yes.

Q. And is it true that in any case, a person would be limited to what is reported?

MR. COFFEY: I object to that. It's leading.

THE COURT: Sustained.

Q. In cases of head trauma, do you feel that all of the aftermath, in your experience, is always reported?

MR. COFFEY: I object to this as leading also.

THE COURT: Sustained.

Q. What is your experience with head trauma with respect to reporting of it?

A. Well, generally, people who see it recognize it and report it. If it happens and they don't see it, they don't recognize it and they don't report it; and if the person who was involved with the head trauma tells you accurately and completely what happened, that's -- that's very helpful; but in many of the cases I do, there's no history.

Q. Now, Mr. Coffey asked you examples from the weekend leading up to [redacted]'s death, and you were asked about signs of potential head trauma based on how [redacted] was acting that weekend. If I told you there was testimony from the mother in this case - that she testified in court - that the baby was crying in the bedroom on Saturday night while she was in the kitchen making dinner, she couldn't see into the bedroom because the door was closed, the baby was crying much louder than normal, so much so she went into the bedroom to check on him, and the baby was alone in the room with the Defendant, would that crying -- could that be a sign of head trauma?

A. It certainly could be.

Q. Why is that?

A. Well, I mean, it depended on when the trauma event occurs. It's often precipitated by crying and the crying can be the baby's response to pain and fear.

MS. BOOK: I have nothing further.

THE COURT: Mr. Coffey, anything else?

RECROSS-EXAMINATION

BY MR. COFFEY:

Q. Doctor, let's talk about something nonspecific. You've got children; right?

A. Yes.

Q. How many children do you have?

A. Two.

Q. So, every time your child cried and was with your husband, did you go running in and ask your husband if he was beating your child?

A. No.

Q. A child cries for a lot of reasons; right?

A. It was a question of a very loud unusual cry that I answered.

Q. Oh. So, what constitutes loud and unusual -- you have no clue really, as you sit here, what loud and unusual means; do you?

A. I think as a mother, you are used to listening to how your baby cries and how your baby reacts; and if they react out of the normal range, you might be concerned.

Q. And when she went into the room, do you know where the baby was?

A. No.

Q. Oh, that's not important?

A. I don't know. She didn't report it.

Q. Actually, the mother did report it. She reported it

to the jury.

A. I wasn't here for that.

Q. I understand that. This was Saturday night; right?

A. Yes.

Q. So, now, maybe the trauma occurs on Saturday night at 11:00?

A. I think it's hard to pin down the exact timing of it. We just know that the baby had acute and old head injuries.

Q. So, if it occurs at nine o'clock on Saturday night, theoretically, then this baby -- and if this baby is developing sepsis, he's now developing sepsis before he gets injured; right?

A. I would assume so.

Q. You got a lot of assumptions here; don't you?

A. I think it's hard to know the exact --

Q. You have a lot of assumptions; don't you?

A. It's difficult to know the exact timing, yes. I have to make some assumptions.

Q. And crying is very nonspecific; isn't it?

A. It is.

Q. Okay. And by the way, I want to ask you one other thing. Leukopenia, what is that?

A. That's a low white count.

Q. And leukopenia is consistent with sepsis; isn't it?

A. It is.

Q. No question about that; right?

A. Yes.

Q. It is not consistent with head trauma; is it?

A. It's not.

MR. COFFEY: That's all I have.

MS. BOOK: Very briefly, Your Honor.

REDIRECT EXAMINATION

BY MS. BOOK:

Q. As Mr. Coffey pointed out, do you agree that mothers are the best historians of their children?

A. Are the best?

Q. Yes.

A. Yes. I think so. I don't know. My husband was very sensitive to my kids when they were little, to their needs. He could have reported it very well, too.

Q. Do you think that if a cry is different than usual, a mother would be the one to know that?

A. I would think that that's something that moms do.

MS. BOOK: Thank you. Nothing further.

THE COURT: Mr. Coffey, anything else?

MR. COFFEY: Thank you, Doctor. That's all I have.

THE COURT: Doctor, you may step down. Thank you. Can I ask the attorneys to approach on the record?

(Sidebar discussion held on the record as